

OKLAHOMA TEMPORARY HIGH RISK POOL INDIVIDUAL CONTRACT

This is your individual Contract of health care and services benefits provided to you by the board of directors of the Oklahoma Health Insurance High Risk Pool (hereinafter referred to as "*Board*"). Please read it now, as it is valuable in assisting you to fully understand your benefits.

In this Contract, "we", "us", and "our" refer to the Oklahoma Health Insurance High Risk Pool Board. Covered persons are called "Insureds", "you", or "your". You are eligible for coverage under this Contract if you are an eligible person as defined.

This Contract is renewable at the end of any coverage period for an additional coverage period, at the Board's option, by acceptance of any premiums determined to be due and payable. This program will continue until January 1, 2014, when Exchanges established under sections 1311 and 1321 of the Affordable Care Act will be available for individuals to obtain health insurance coverage. The availability and unavailability of membership in the Oklahoma Temporary High Risk Pool and any benefit through the plan are at all times subject to federal law, regulations, and the agreement between the Oklahoma Health Insurance High Risk Pool Board and the U.S. Department of Health and Human Services, and is dependent on continued availability of federal funding.

The coverage period is the period of time covered by your billing notice, which was established at the beginning of your first coverage period under this Contract.

This Contract is not cancelable by the board during a coverage period, except for non-payment of premiums, or for fraud or material misrepresentation made in any statement, application, claim or other form submitted to obtain this Contract or any of its benefits, or change in eligibility.

Carefully read this Contract as soon as you receive it. If you are not satisfied for any reason, you may return it to us within 10 days after you receive it. We will refund all of the premiums paid to you within 30 days after the Contract is returned.

You should carry your Identification Card with you at all times. Present your card to the Hospital, Physician or other Provider of health care when applying for admission or services.

Please notify the Plan Administrator of any change of address and of any change in employment status for yourself or anyone else in your household that may affect your eligibility for group health coverage. In corresponding with the Plan always refer to your identification number which appears on your Identification Card.

The Plan is operated under an administrative services agreement between the Board 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. Blue Cross and Blue Shield of Oklahoma provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

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

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SECTION I – SCHEDULE OF BENEFITS FOR COVERED HEALTH CARE SERVICES

BENEFIT PERIOD	Calendar Year
DEDUCTIBLE	\$2,000 per Calendar Year
LIFETIME MAXIMUM BENEFIT	\$1,000,000 per lifetime per Insured
ANNUAL MEDICAL COVERAGE OUT-OF-POCKET EXPENSE LIMIT	\$4,350 (including deductible and coinsurance)
ANNUAL PRESCRIPTION DRUG COVERAGE OUT-OF-POCKET EXPENSE LIMIT	\$1,600 (including deductible and copays)
COINSURANCE	80% of the Blue Preferred allowable amount in-network 60% of the Blue Traditional allowable amount out-of-network
OUTPATIENT PRESCRIPTION DRUGS (MAXCARE)	<p>\$200 deductible per calendar year</p> <p>Retail Pharmacy Benefits (30 days supply at network pharmacies)</p> <p>Therapeutic Substitution Opportunity Generic Drugs (TSO): \$5 \$10 copay for Generic drugs after deductible \$35 copay for Formulary Brand drugs after deductible, plus cost difference if generic available \$60 copay for Non-Formulary Brand drugs after deductible, plus cost difference if generic available \$150 copay for Specialty/Biotech drugs</p> <p>Mail-at-Retail (90 day supply at network pharmacies)</p> <p>Therapeutic Substitution Opportunity Generic Drugs (TSO): \$10 \$30 copay for Generic drugs after deductible \$105 copay for Formulary Brand drugs after deductible, plus cost difference if generic available \$180 copay for Non-Formulary Brand drugs after deductible, plus cost difference if generic available</p> <p>This benefit is available only for prescriptions purchased through the pharmacy card or its related mail-at-retail extended supply option. Should there be a generic drug available at dispensing and yet the plan participant requests the name brand drug, then the Insured pays the generic copay plus the difference in cost between the generic and name brand drug.</p>

MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES	Inpatient and Outpatient: 80% of allowable charges after deductible in-network 60% of allowable charges after deductible out-of-network
INPATIENT AND OUTPATIENT HOSPITAL SERVICES (includes Rehabilitation Care)	80% of allowable charges after deductible in-network 60% of allowable charges after deductible out-of-network
OUTPATIENT EMERGENCY CARE (maximum benefit – 180 days per calendar year)	80% of allowable charges after deductible
SKILLED NURSING FACILITIES	80% of allowable charges after deductible in-network 60% of allowable charges after deductible out-of-network
HOSPICE CARE (lifetime maximum benefit - \$10,000)	80% of allowable charges after deductible in-network 60% of allowable charges after deductible out-of-network
HOME HEALTH CARE (maximum benefit – the lesser of 60 days or \$5,000 per calendar year)	80% of allowable charges after deductible in-network 60% of allowable charges after deductible out-of-network
PHYSICIAN SERVICES	80% of allowable charges after deductible in-network 60% of allowable charges after deductible out-of-network
WELL CARE - routine physical exams, immunizations, routine diagnostic tests	100% no deductible
SPEECH, OCCUPATIONAL AND PHYSICAL THERAPY (combined maximum benefit - \$2,000 per calendar year)	80% of allowable charges after deductible in-network 60% of allowable charges after deductible out-of-network
TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ) and Related Disorders	80% of allowable charges after deductible in-network 60% of allowable charges after deductible out-of-network
OTHER COVERED SERVICES (ambulance services, medical supplies, durable medical equipment)	80% of allowable charges after deductible in-network 60% of allowable charges after deductible out-of-network

SECTION II – PRECERTIFICATION

A. PRECERTIFICATION

The Plan has designated certain Covered Services which require “*Precertification*” in order for you to receive the maximum Benefits possible under the Contract. To request Precertification, you or your Provider may simply call the telephone number shown on your identification card.

For an Inpatient facility stay, *you must request Precertification from the Plan before your scheduled admission*. The Plan will consult with your Physician, Hospital, or other facility to determine if Inpatient level of care is required for your illness or injury. The Plan may decide that the treatment you need could be provided just as effectively in a less expensive setting (such as the Outpatient department of the Hospital, an Ambulatory Surgical Facility, or the Physician’s office). If the Plan determines that 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 Plan’s approval, or if you do not ask the Plan for Precertification, your Benefits under this Contract will be reduced by 20% for that admission, provided the Plan determines that Benefits are payable upon receipt of a claim.** This reduction applies *in addition* to any penalties associated with your use of an Out-of-Network Provider.

1. Precertification Requests Involving Non-Urgent Care

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

If we determine that additional time is necessary, the Plan 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 Plan expects to make the determination.

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

2. 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 determinations:

- a. could seriously jeopardize the life or health of the Insured or the ability of the Insured to regain maximum function; or
- b. in the opinion of a Physician with knowledge of the Insured’s medical condition, would subject the Insured 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 Plan 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 Plan 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 Plan’s response to your Precertification request no later than 48 hours after the earlier of (1) the Plan’s receipt of the specified information, or (2) the end of the 48-hour period you were given to provide the specified information.

NOTE: The Plan’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.

3. 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 your Contract if you or your Provider notifies the Plan within two working days following your emergency admission.

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

Please keep in mind that any treatment you receive which is not a Covered Service under this Contract, or which is not Medically Necessary, will be excluded from your Benefits.

B. CONCURRENT REVIEW AND CASE MANAGEMENT

As part of the Precertification process described above, the Plan will determine an “expected” or “typical” length of stay or course of treatment based upon the medical information given to the Plan 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 this Contract.

Whenever it is determined that Inpatient care or an ongoing course of treatment may no longer be Medically Necessary, the Plan’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 Plan 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 request to extend care beyond the approved time limit, and it is a Request Involving Urgent Care, the Plan 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.

SECTION III – DEFINITIONS

This section defines terms that have special meanings in your Contract. 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.

- A. ALLOWABLE CHARGE – for Covered Health Care Services, the “Allowable Charge” will be determined as follows:
1. **BluePreferred PPO or BlueCard PPO Providers** – 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 PPO Provider Agreement.
 2. **BlueTraditional Providers** – 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 BlueTraditional Provider Agreement.
 3. **Oklahoma Out-of-Network Providers** – the Provider’s usual charge, up to the amount that the Plan would reimburse a BlueTraditional Provider for the same service.
 4. **Out-of-Network Providers** (outside the state of Oklahoma) – the Provider’s usual charge, up to the amount that the on-site Blue Cross and Blue Shield Plan would reimburse a BlueCard PPO Provider for the same service.

NOTE: For Covered Services Incurred outside the state of Oklahoma, the “Allowable Charge” will be determined by the Blue Cross and Blue Shield Plan (Host Plan) servicing that area. Payment will be based upon the Provider payment arrangements in effect between the Provider and the on-site Plan.

- B. AMBULATORY SURGICAL FACILITY – a Provider with an organized staff of Physicians which:
1. Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
 2. Provides treatment by of under the supervision of Physicians and nursing services whenever the patient is in the facility;
 3. Does not provide Inpatient accommodations; and
 4. Is not, other than incidentally, a facility used as an office or clinic for the private practice of a Physician or other Provider.
- C. BENEFIT PERIOD – the specified period of time (stated on page 4 of the Contract) during which charges for Covered Services must be Incurred in order to be eligible for payment. A charge is Incurred on the date the service or supply was provided to an Insured.
- D. BENEFITS – the payment, reimbursement and indemnification of any kind which an Insured will receive from and through the Plan under this Contract.
- E. BIRTHING CENTER – A freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery and delivery; provide care under the full-time supervision of a Physician and either a Registered Nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre or post delivery confinement.

- F. BLUECARD PPO PROVIDER – The nationwide 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.
- G. BLUECHOICE PPO PROVIDER – A Provider who has entered into an agreement with the Plan Administrator to bill them directly for Covered Services, and to accept the Plan Administrator’s allowance as payment for such Covered Services.
- H. BLUEPREFERRED PROVIDER – A Provider who has entered into a BluePreferred Provider agreement with the Plan Administrator to bill them directly for Covered Services, and to accept the Plan Administrator’s allowance as payment for such Covered Services.
- I. CALENDAR YEAR – the period of 12 months commencing the first day of January and ending on the last day of the following December.
- J. CHIROPRACTIC SERVICES – Medical Care, including office visits, Diagnostic Services and Therapy Services.
- K. COINSURANCE - The *percentage* of Allowable Charges for Covered Services for which the Covered Person is responsible.
- L. COMMUNITY HOME HEALTH CARE AGENCY – a Provider which:
 - 1. Provides skilled nursing and other services on a visiting basis in the Insured’s home; and
 - 2. Is responsible for supervising the delivery of such services under a plan prescribed by a Physician
- M. CONTRACT – this agreement (including the Application, Identification Card, and any Amendment or Endorsement) between you and the Board, as limited or restricted by the terms of the Patient Protection and Affordable Care Act. This agreement may be referred to as the Oklahoma Temporary High Risk Pool Individual Contract. This agreement is issued pursuant to, and is governed by, the terms of the Patient Protection and Affordable Care Act. In the event of a conflict between the terms of this Agreement and the terms of the Act, the provisions of the Act will control.
- N. COPAYMENT (COPAY) – A fixed dollar amount required to be paid by or on behalf of a Covered Person in connection with the delivery of some Covered Services (e.g., Physician's office visits, Hospital emergency room visits, and Prescription Drugs).
- O. COVERED SERVICE – a service or supply specified in this Contract for which Benefits will be provided when rendered by a Provider.
- P. CREDITABLE COVERAGE – means, with respect to an individual, coverage of the individual provided under any of the following: a group health plan; health insurance coverage; Part A or Part B of Title XVIII of the Social Security Act (Medicare); Title

XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928; Chapter 55 of Title 10, United States Code; a medical care program of the Indian Health Service or of a tribal organization; a State health benefits risk pool; a health plan offered under chapter 89 of Title 5, United States Code (the Federal Employees Health Benefits Program); a public health plan as defined in federal regulations; a health plan benefit under section 5(e) of the Peace Corps Act (22 U.S.C. 2504 (e) or a health plan issued in compliance with Title XXI of the Social Security Act, Children's Health Insurance Program.

- Q. 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.
- R. DEDUCTIBLE – a specified amount of Covered Services that an Insured must incur before the Plan will start to pay its share of the remaining Covered Services.
- S. DENTIST – A professional practitioner who holds a lawful license issued by any state of the United States, or its territories, authorizing the person to practice dentistry and dental Surgery in such state or territory, including, but not limited to, a Doctor of Dental Surgery (DDS) or a Doctor of Medical Dentistry (DMD).
- T. 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.
 - 1. radiology, ultrasound, and nuclear medicine
 - 2. laboratory and pathology
 - 3. ECG, EEG, and other electronic diagnostic medical procedures and physiological medical testing, as determined by the Plan.
- U. DURABLE MEDICAL EQUIPMENT – Equipment which meets the following criteria:
 - 1. It provides therapeutic benefits or enables the Insured to perform certain tasks that he or she would be unable to perform otherwise due to certain medical conditions and/or illnesses;
 - 2. It can withstand repeated use and is primarily and customarily used to serve a medical purpose;
 - 3. 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
 - 4. It is prescribed by a Physician and meets the Plan Administrator's criteria of Medical Necessity for the given diagnosis.
- V. EFFECTIVE DATE – according to the Eligibility section, the date on which coverage for an Insured begins under this Contract.
- W. ELIGIBLE PERSON – a person entitled to apply to be an Insured as specified in the Eligibility section
- X. 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 immediate medical attention to result in:
 - 1. serious jeopardy to the Covered Person's health;
 - 2. serious impairment to bodily function; or
 - 3. serious dysfunction of any bodily organ or part.

- Y. ENROLL – To become covered for Benefits under the Contract (i.e., when coverage becomes effective), without regard to when the individual may have completed or filed any forms that are required in order to Enroll for coverage.
- Z. EXPERIMENTAL/INVESTIGATIONAL – a drug, device, biological product, or medical treatment or procedure is Experimental or Investigational if the Plan determines that:
1. 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;
 2. 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
 3. 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.
- AA. 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.
- BB. HOSPICE – a Provider which provides an integrated set of services designed to provide palliative and supportive care to terminally ill patients and their families.
- CC. HOSPITAL – a Provider that is a short-term, acute care, general hospital which:
1. Is a duly licensed institution
 2. Mainly provides Inpatient diagnostic and therapeutic services under the supervision of Physicians;
 3. Has organized departments of medicine and major Surgery;
 4. Provides 24-hour nursing service; and
 5. Is not, other than incidentally, a:
 - a. Skilled Nursing Facility;
 - b. Nursing home;
 - c. Custodial Care home;
 - d. Health resort;
 - e. Spa or sanitarium;
 - f. Place for rest;
 - g. Place for the aged;
 - h. Place for the provision of Hospice care;
 - i. Place for the provision of rehabilitation care;
 - j. Place for the treatment of pulmonary tuberculosis.
- DD. HOSPITAL ADMISSION – The period from your entry (admission) into a Hospital for Inpatient treatment until your discharge.

- EE. IDENTIFICATION CARD – the card issued to the Insured by the Plan, bearing the Insured’s name, and identification number.
- FF. ILLNESS – A bodily disorder, disease, physical sickness or Mental Illness. Illness includes pregnancy, childbirth, miscarriage or complications of pregnancy.
- GG. INCURRED – a charge is Incurred on the date you receive a service or supply for which a charge is made.
- HH. INJURY – an accidental physical Injury to the body caused by unexpected external means
- II. 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.
- JJ. INSURED – an Eligible Person as specified in the **“Eligibility, Enrollment, Changes and Termination”** section.
- KK. LICENSED PRACTICAL OR VOCATIONAL NURSE (LPN OR LVN) – a licensed nurse with a degree from a school of practical or vocational nursing.
- LL. MAMMOGRAPHY – the x-ray *screening* examination of the breast using equipment dedicated specifically for mammography, including but not limited to the x-ray tube, filter, compression device, screens, films, and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast.
- MM. MATERNITY SERVICES – care required as a result of being pregnant, including prenatal care and postnatal care.
- NN. MEDICAL CARE – professional services given by a Physician or other Provider to treat Illness or Injury.
- OO. MEDICALLY NECESSARY – a service or supply provided by a Hospital, Physician or other Provider which the Plan determines is:
1. Appropriate for symptoms and diagnosis to treat the condition, Illness, disease or Injury; and
 2. In line with standards of good medical practice; and
 3. Not primarily for your or your Provider’s convenience; and
 4. The most appropriate supply or level of service which can be safely provided to you. When applied to the care of an Inpatient, this means that your condition or the services you need require acute care as a bed patient and that you cannot receive safe or adequate care as an Outpatient.
- PP. MEDICAL/SURGICAL SUPPLIES – means items for medical use other than drugs, Prosthetic or Orthotic Appliances, Durable Medical Equipment, or orthopedic footwear which have been ordered by a Physician in the treatment of a specific medical condition and which are usually:
1. consumable;
 2. non-reusable;
 3. disposable;
 4. for a specific rather than incidental purpose; and
 5. generally have no salvageable value.

- QQ. MEDICARE – the programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.
- RR. 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.
- SS. ORGAN PROCUREMENT SERVICES – The services provided to match the human organ donor to the transplant recipient, surgically remove the organ from the donor and transport the organ to the location of the recipient within 24 hours after the match is made.
- TT. ORTHOGNATHIC SURGERY – Services or supplies received for corrections of deformities of the jaw, including the surgical repositioning of portions of the upper or lower jaws or the bodily repositioning of entire jaws.
- UU. OUT-OF-NETWORK PROVIDER – a Provider that has not entered into an agreement with the Plan Administrator to be a part of its BluePreferred PPO or with another Blue Cross and Blue Shield Plan to be a part of the BlueCard PPO Provider network.
- VV. OUT-OF-POCKET MAXIMUM – a specified dollar amount of expense Incurred after the Deductible amount by a Covered Person for Covered Services in a Calendar Year. The Out-of-Pocket Maximum includes the Deductible, but *does not* include the following:
1. Precertification penalties;
 2. Charges in excess of the Allowable Charge.
- When the Out-of-Pocket Maximum is reached, the level of Benefits is increased as specified in the **Schedule of Benefits**.
- WW. OUTPATIENT – a Covered Person who receives services or supplies while not an Inpatient.
- XX. OUTPATIENT FACILITY – a facility (located in or apart from a hospital) for the diagnosis or diagnosis and treatment of ambulatory patients (including ambulatory inpatients):
1. which is operated in connection with a hospital;
 2. in which patient care is under the professional supervision of persons licensed to practice medicine or surgery in the State, or, in the case of dental diagnosis or treatment, under the professional supervision of persons licensed to practice dentistry in the State; or
 3. which offers to patients not requiring hospitalization the services of licensed Physicians in various medical specialties, and which provides to its patients a reasonably full-range of diagnostic and treatment services.
- YY. 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.

- ZZ. PLAN –the Contract provided by the Oklahoma Temporary High Risk Pool Board of Directors or “Board”.
- AAA. PLAN ADMINISTRATOR – the person or entity designated by the Oklahoma Temporary High Risk Pool Board who has the discretion and authority to control and manage the operation of the Plan.
- BBB. PRECERTIFICATION – Certification from the Plan 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 Plan 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.
- CCC. PRESCRIPTION DRUG/MEDICATION –
1. Any medicinal substance (including contraceptive medications, regardless of Medical Necessity) required by the Federal Food, Drug and Cosmetic Act to bear the following legend on its label: “Caution: Federal Law prohibits dispensing without prescription”;
 2. A medication compounded by a Pharmacist which contains a Prescription Drug; and
 3. Injectable insulin;
 4. Prescription Drugs prescribed and used for cosmetic purposes are not covered.
- DDD. PROOF OF LOSS – a formal statement or claim regarding a loss which provides sufficient information to allow the Plan to determine its liability for Covered Services. This includes: a completed claim form; the Provider’s itemized statement of services rendered and related charges; and medical records, when requested by the Plan, as provided under the utilization review procedures of this Contract.
- EEE. PROPERLY FILED CLAIM – A formal statement or claim regarding a loss which provides sufficient, substantiating information to allow the Plan Administrator to determine the Plan’s liability for Covered Services. This includes: a completed claim form; the Provider’s itemized statement of services rendered and related charges; and medical records, when requested by the Plan Administrator.
- FFF. 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.
- GGG. REGISTERED NURSE – a licensed nurse with a degree from a school of nursing.
- HHH. RESIDENT – an individual who maintains a primary residence in the State of Oklahoma.
- III. 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.
- JJJ. ROUTINE NURSERY CARE – Ordinary Hospital nursery care of the newborn Covered Person.

- KKK. 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:
1. Custodial Care, ambulatory, or part-time care; or
 2. Treatment for Mental Illness, alcoholism, drug abuse or pulmonary tuberculosis.
- LLL. SPECIALTY/BIOTECH MEDICATIONS – typically used to treat chronic, high-cost diseases. These products often have a biological basis (e.g. blood products or insulin) rather than chemical basis. Because the drug molecules of these medications may be large, they are often administered via injection or infusion. However, oral Biotech/specialty medications are available in many cases. Special handling or storage may be required. The average cost of these medications is around \$1500.
- MMM. SURGERY –
1. The performance of generally accepted operative and other invasive procedures;
 2. The correction of fractures and dislocations;
 3. Usual and related preoperative and postoperative care.
- NNN. THERAPY SERVICE – the following services and supplies ordered by a Physician when used to treat and promote your recovery from an Illness or Injury:
1. **Radiation Therapy** – the treatment of disease by x-ray, radium, or radioactive isotopes.
 2. **Chemotherapy** – the treatment of malignant disease by chemical or biological antineoplastic agents.
 3. **Respiratory Therapy** – introduction of dry or moist gases into the lungs for treatment purposes.
 4. **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.
 5. **Physical Therapy** – the treatment by physical means, chiropractic, 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.
 6. **Speech Therapy** – treatment for the correction of a speech impairment resulting from disease, Surgery, Injury, congenital and developmental anomalies, or previous therapeutic processes.
 7. **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.
- OOO. URGENT CARE – Treatment for an unexpected Illness or Injury that is not life-threatening but for which treatment cannot be reasonably postponed.

SECTION IV – ELIGIBILITY, ENROLLMENT, CHANGES AND TERMINATION

This section explains who is eligible for Benefits under this Contract. It tells:

- Who is considered an Eligible Person,
- How and when your coverage becomes effective,
- When your coverage under this Contract ends; and
- What rights you have when your coverage stops.

A. ELIGIBLE PERSON

An individual may apply for coverage under this Contract if he or she:

1. is a citizen or national of the United States or lawfully present in the United States and is a legal resident of the state of Oklahoma; and
2. has not been covered under creditable coverage at any time during the six (6) month period of time prior to the date on which such individual is applying for coverage in the Oklahoma Temporary High Risk Pool; and
3. meets the pre-existing condition requirement in section IV.B.

Dependents are not eligible for coverage under this Contract.

B. PRE-EXISTING CONDITION REQUIREMENT

1. Individual must provide documented proof of **at least one** of the following qualifying conditions:
 - a. Unable to obtain comprehensive health care insurance from an insurer in the State of Oklahoma;
 - b. Was offered, but does not currently have, insurance with an exclusionary rider/waiver from an insurer in the State of Oklahoma;
 - c. In the case of a child under the age of 19, any health condition for which the child receives a rating of 125% or greater of the insurance carrier's standard rate;
 - d. A statement from a physician, signed and dated within the past 12 months verifying that the individual previously had, or currently has, a medical condition(s) to include the name(s) of the medical condition(s).

NOTE: Requirements under section 4.A.2 will be waived for Individuals who were members of a Pre-existing Condition Insurance Plan or Temporary High Risk Pool in another state upon the establishment of Oklahoma residency.

C. EFFECTIVE DATE

1. To enroll for coverage under this Contract, the Eligible Person must complete an application provided by the Plan, including all information needed to determine eligibility. The Effective Date will be determined by the Plan, based upon the date application is received in the Plan offices.
2. In the case of a newborn child, coverage will be effective on the date of birth if born to a female Insured. Child will be covered for the first 31 days of life under the maternity services provided in this Contract.

D. TERMINATION OF AN INSURED'S COVERAGE

1. This Contract is not cancelable by the Board during a coverage period, except for:
 - a. Non-payment of premiums.
 - b. Presenting checks with insufficient funds.
 - c. Moving outside the state of Oklahoma.
 - d. Reaching age 65 if enrolled for Medicare.
 - e. Securing other health insurance. If it is determined that the enrollee has other insurance, the enrollee can be terminated retroactively to the date the other insurance became effective, up to six (6) months.
 - f. Death. The effective date of termination will be the day after the date of death.
2. Insureds who become ineligible or who no longer want to be covered by the Oklahoma Temporary High Risk Pool will have their membership terminated no later than 45 days from the date of ineligibility and usually the first day of the month following verification of ineligibility.
3. In the case of a newborn child, coverage will only be provided under the female Insured's Contract during the first 31 days of life under the maternity services provided in this Contract. Coverage for the newborn will terminate the day following 31 days of life.
4. Any person who is covered under this Plan and who terminates their coverage will not be eligible again until six (6) months has elapsed since the coverage was terminated.
5. If applicable, payment made for coverage beyond the termination date specified above will be refunded to the Insured.
6. An Insured's coverage shall be terminated retroactive to the Effective Date if the Insured commits fraud or material misrepresentation in applying for or obtaining coverage under this Contract. An Insured's coverage shall terminate immediately if he or she files a fraudulent claim.

E. BENEFITS AFTER TERMINATION OF COVERAGE

1. If an Insured's coverage terminates for any reason, Benefits under this Contract shall cease as of the effective date and time of such termination. However, if the termination of coverage is caused by failure to pay premiums on behalf of the Insured, a forty-five (45) day grace period will be observed on behalf of the plan. During this grace period, the Contract shall remain in force. If past due premiums are not paid within the forty-five (45) day grace period then the Insured's coverage will be terminated with an effective date equal to their last premium "paid to" date. Any claims paid for service after the termination date will be pursued for refunds.
2. The Plan shall have no liability for any Benefits for Covered Services Incurred after the termination of this Contract, except as provided above.

SECTION V – COVERED HEALTH CARE SERVICES

Subject to the Exclusions, conditions, and limitations of this Contract, an Insured is entitled to the Benefits of this section for Covered Services rendered by a Hospital, Physician, or other Provider in the amounts specified in the Schedule of Benefits.

The following are Covered Services:

A. HOSPITAL SERVICES

1. Bed, board, and general nursing service when an Insured is an Inpatient in:
 - a. a room with two or more beds;
 - b. a private room. Private room allowance is equal to the most prevalent semiprivate room charges of the Hospital in which the Insured is hospitalized in effect on the date of the patient's admission. If the Hospital has only private rooms and rates, the Plan will determine the covered room charge. Private room charges in excess of the semiprivate room rate 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;
 - c. a bed in a Special Care Unit - a designated unit which has concentrated all facilities, equipment, and supportive services for the provision of an intensive level of care of critically ill patients.
2. Ancillary Services, Hospital services and supplies including, but not restricted to:
 - a. use of operating, delivery, and treatment rooms;
 - b. prescribed medications;
 - c. whole blood, administration of blood, and blood processing;
 - d. anesthesia, anesthesia supplies and services rendered by an employee of the Hospital or other Provider;
 - e. medical and surgical dressings, supplies, casts, and splints;
 - f. oxygen;
 - g. subdermally implanted devices or appliances necessary for the improvement of physiological function;
 - h. Diagnostic Services;
 - i. Therapy Services.
3. Outpatient emergency Hospital services and supplies to treat injuries caused by an accident.
4. Outpatient emergency Hospital services and supplies to treat a sudden and acute medical condition that requires prompt Medical Care.

5. Surgery Hospital services and supplies for Outpatient Surgery including removal of sutures, anesthesia, anesthesia supplies and services rendered by an employee of the Hospital or other Provider other than the surgeon or assistant surgeon.
6. Inpatient mental health and alcoholism and drug addiction services.

B. SURGICAL/MEDICAL SERVICES

1. Surgical Services

a. Surgery

- 1) Surgery performed by a Physician or other Provider. Separate payment will not be made for preoperative and postoperative services.
- 2) If an incidental procedure¹ 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.
- 3) If more than one primary surgical procedure is performed through more than one route of access during one operation, the total Benefits payable will be calculated as follows:
 - a) the amount payable for the primary procedure; plus
 - b) 50% of the amount that would have been payable for each of the additional procedures had those procedures been performed alone.

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

c. Anesthesia Administration of anesthesia ordered by the attending Physician and rendered by a Physician or other Provider other than the surgeon or assistant surgeon.

2. Inpatient Medical Services

Medical Care by a Physician or other Provider to an Insured who is a Hospital Inpatient for a condition not related to Surgery, Pregnancy or Mental Illness, except as specifically provided.

a. Inpatient Medical Care Visits

b. Intensive Medical Care

Medical Care rendered to an Insured whose condition requires a Physician's constant attendance and treatment for a prolonged period of time.

¹ 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.

c. Concurrent Care

- 1) Medical Care rendered concurrently with Surgery during one Hospital stay by a Physician other than the operating surgeon for treatment of a medical condition separate from the condition for which Surgery was performed.
- 2) Medical Care by two or more Physicians rendered concurrently during one Hospital stay when the nature or severity of the Insured's condition requires the skills of separate Physicians

d. Consultation

Consultation services rendered to a Hospital Inpatient by another Physician at the request of the attending Physician, **limited to one visit or other service per day for each consulting Physician.** Consultation does not include staff consultations which are required by Hospital rules and regulations.

- e. Newborn Well Baby Care (three days). The initial Inpatient visit to examine a newborn Insured.

3. Outpatient Medical Services

Medical Care rendered by a Physician or other Provider to an Insured who is an Outpatient for a condition not related to Surgery, Pregnancy or Mental Illness, except as specifically provided.

a. Emergency Accident Care

Treatment of accidental bodily injuries.

b. Emergency Medical Care

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

- c. Home, Office and Other Outpatient Visits and consultation for the examination, diagnosis, and treatment of an injury or illness.

b. Child Health Supervision Services

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. Child Health Supervision Services must be rendered during a periodic review, provided by or under the supervision of a single Physician during the course of one visit. The periodic review must be conducted within the following frequency schedule:

- 1) Up to six reviews in the first year following the child's birth;
- 2) Up to two reviews for children between the ages of one and two;
- 3) One review each year for children ages three through six; and
- 4) One review every two years for children ages seven through 18.

Child Health Supervision Services are limited to Insureds under age 19.

- c. Immunizations, from birth to age 19, covered immunizations shall not be subject to deductible, copay or coinsurance and shall include the immunizations as described below:

Immunizations combined or administered separately as recommended by the Oklahoma State Department of Health; and Human Papillomavirus “Gardasil.”

C. OUTPATIENT DIAGNOSTIC SERVICES

1. 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:
 - a. one screening examination for female Insureds age 35 through 39; and
 - b. one annual screening examination for female Insureds age 40 or older. Benefits for routine Mammography are paid at 100% not subject to deductibles, per screening per Insured.
2. Laboratory and Pathology
3. ECG, EEG, and Other Electronic Diagnostic Medical Procedures and Physiological Medical Testing, as determined by the Plan.

D. OUTPATIENT THERAPY SERVICES

1. Radiation Therapy
2. Chemotherapy
3. Respiratory Therapy
4. Dialysis Treatment
5. Physical Therapy
6. Occupational Therapy
7. Speech Therapy

Benefits for Outpatient Physical Therapy, Chiropractic Therapy, Outpatient Occupational Therapy, and Outpatient Speech Therapy are limited to a combined maximum of \$2,000 per Benefit Period per Insured.

E. MATERNITY SERVICES

Hospital Services and Surgical/Medical Services rendered by a Hospital, Physician or other Provider, not including the services of midwives, to an Insured for:

1. Normal Pregnancy

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

2. 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.

3. Interruptions of Pregnancy (Miscarriage)

4. The benefit levels for Maternity Coverage are as follows:

- a. Forty-eight (48) hours of inpatient care at a hospital or birthing center licensed as a hospital, following a vaginal delivery for mother and newborn infant after childbirth.
- b. Ninety-six (96) hours of inpatient care at a hospital following delivery by cesarean section for the mother and newborn infant after childbirth.
- c. 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 forty-eight (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:
 - 1) physical assessment of the mother and newborn infant;
 - 2) parent education regarding childhood immunizations;
 - 3) training or assistance with breast or bottle feeding; and
 - 4) 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.

5. Inpatient care shall include:

- a. Physical assessment of the mother and the newborn infant;
- b. Parent education concerning the recommended childhood immunization schedule, the importance of childhood immunizations, resources for obtaining childhood immunizations, training or assistance with breast or bottle feeding and the performance of any medically necessary and appropriate clinical tests.

6. The plan may provide coverage for a shorter length of hospital inpatient stay for services related to maternity and newborn infant care provided that 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:

- a. evaluation of the antepartum, intrapartum and postpartum course of the mother and newborn infant,
- b. the gestational age, birth weight and clinical condition of the newborn infant,

- c. the demonstrated ability of the mother to care for the newborn infant post-discharge, and
 - d. the availability of post-discharge follow-up to verify the condition of the newborn infant in the first forty-eight (48) hours after delivery.
7. The plan covers one home visit, within forty-eight (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:
- a. physical assessment of the mother and the newborn infant,
 - b. parent education regarding childhood immunizations;
 - c. training or assistance with breast or bottle feeding; and
 - d. the performance of any Medically Necessary and appropriate clinical tests.

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

F. 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 Plan for assessing and selecting Providers for transplants.

Precertification must be obtained at the time the Insured is referred for a transplant consultation and/or evaluation. It is the Insured'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.

1. Definitions

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

a. Bone Marrow Transplant

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

- 1) 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);
- 2) processing and/or storage of the stem cells or progenitor cells after harvesting;
- 3) the administration of High-Dose Chemotherapy and/or High-Dose Radiation Therapy, when this step is prescribed by the treating Physician;
- 4) the infusion of the harvested stem cells or progenitor cells; and
- 5) 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.

b. 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.

c. 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.

d. Precertification

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

e. 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.

2. Transplant Services

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

- a. Musculoskeletal transplants;
- b. Parathyroid transplants;
- c. Cornea transplants;
- d. Heart-valve transplants;
- e. Kidney transplants;
- f. Heart transplants;
- g. Single lung, double lung and heart/lung transplants;
- h. Liver transplants;
- i. Intestinal transplants;
- j. Small bowel/liver or multivisceral (abdominal) transplants;

- k. Pancreas transplants;
 - l. Islet cell transplants; and
 - m. Bone Marrow Transplants.
3. Exclusions and Limitations Applicable to Organ/Tissue/Bone Marrow Transplants
- a. The transplant must meet the criteria established by the Plan for assessing and performing organ or tissue transplants, or Bone Marrow Transplant procedures, as set forth in the Plan's written medical policies.
 - b. In addition to the Exclusions set forth elsewhere in the Contract, no Benefits will be provided for the following organ or tissue transplants or Bone Marrow Transplants or related services:
 - 1. Adrenal to brain transplants.
 - 2. Allogeneic islet cell transplants.
 - 3. 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.
 - 4. Small bowel transplants using a living donor.
 - 5. 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.
 - 6. Any artificial device for transplantation/implantation, except in limited instances as reflected in the Plan's written medical policies.
 - 7. Any organ or tissue transplant or Bone Marrow Transplant procedure which the Plan considers to be Experimental or Investigational in nature.
 - 8. 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 Insured recipient.
 - 9. All services, provided directly for or relative to any organ or tissue transplant, or Bone Marrow Transplant procedure which is not specifically listed as a Covered Service in this Contract.
 - c. The transplant must be performed in and by a Provider that meets the criteria established by the Plan for assessing and selecting Providers in the performance of organ or tissue transplants, or Bone Marrow Transplant procedures.

4. Donor Benefits

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

- a. When both the recipient and the living donor are Insureds, each is entitled to the Benefits of the Contract.
- b. When only the recipient is an Insured, both the donor and the recipient are entitled to the Benefits of the Contract. The donor Benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage or other Blue Cross or Blue Shield coverage or any

- c. When only the living donor is an Insured, the donor is entitled to the Benefits of the Contract. The Benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage or other Blue Cross or Blue Shield coverage or any government program available to the recipient. There are no Covered Services for the non-Insured transplant recipient.
 - d. If any organ or tissue or bone marrow or stem cells or progenitor cells are sold rather than donated to the Insured recipient, no Covered Services will be provided for the purchase price, evaluation, Procurement Services or procedure.
 - e. The Plan is not liable for transplant expenses Incurred by donors, except as specifically provided.
5. Research-Urgent Bone Marrow Transplant Benefits within National Institutes of Health Clinical Trials Only

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

- a. It is therapeutic (not diagnostic or supportive) treatment used to directly improve health outcomes for a condition that is life threatening and that has a poor prognosis with the most effective conventional treatment. For purposes of this provision, a condition is considered life threatening if it has a substantial probability of causing premature death and all other conventional treatments have failed, or are not medically appropriate;
- b. The Bone Marrow Transplant is available to the Insured seeking it and will be provided within a clinical trial conducted or approved by the National Institutes of Health;
- c. The Bone Marrow Transplant is not available free or at a reduced rate; and
- d. The Bone Marrow Transplant is not excluded by another provision of the Contract.

G. AMBULATORY SURGICAL FACILITY SERVICES

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

- 1. such services are Medically Necessary;
- 2. an operative or cutting procedure, which due to clinical circumstances cannot be done in a Physician's office, is actually performed; and
- 3. the operative or cutting procedure is a Covered Service under this Contract.

H. MENTAL AND NERVOUS / ALCOHOLISM / DRUG ADDICTION TREATMENT

The treatment of mental and nervous conditions, alcoholism and drug addiction, includes the following:

- 1. Inpatient Facility Services

Hospital Services provided for the Inpatient treatment by a Hospital or other Provider. All such services must be precertified.

2. Inpatient Medical Services

All the following services provided for the Inpatient treatment by a Physician or other Provider:

a. Medical Care Visits

Inpatient Medical Care visits are limited to one visit or other service per day.

b. Individual Psychotherapy

c. Psychological Testing

d. Convulsive Therapy Treatment

Electroshock treatment or convulsive drug therapy including anesthesia when administered concurrently with the 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.

3. Outpatient Services

a. Facility and Medical Services

Covered Inpatient Facility and Medical Services when provided for the Outpatient treatment by a Hospital, Physician, or other Provider.

b. Day/Night Services

Treatment of Alcoholism or Drug Addiction in a planned therapeutic program when such services are rendered by a Plan-approved facility during the day only or during the night only.

Outpatient Convulsive Therapy Treatment is excluded.

I. SERVICES RELATED TO TREATMENT OF AUTISM AND AUTISM SPECTRUM DISORDERS

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

a. Autistic disorder — childhood autism, infantile psychosis and Kanner's syndrome;

b. Childhood disintegrative disorder — Heller's syndrome;

c. Rett's syndrome; and

d. Specified pervasive developmental disorders — Asperger's disorder, atypical childhood psychosis and borderline psychosis of childhood.

2. Benefits for treatment of autism and autism spectrum disorders are limited as follows:
 - a. Subscribers under age six shall be entitled to a combined maximum of three hundred ninety (390) visits for Physical Therapy, Occupational Therapy and Speech Therapy per Benefit Period.
 - b. Subscribers age six and older are subject to the limitations specified under “Outpatient Therapy Services” for visits related to Speech Therapy, Physical Therapy and Occupational Therapy.

Other Covered Services related to the treatment of autism or autism spectrum disorders, as specified in the Contract, shall not be subject to a Benefit Period maximum.

J. AMBULANCE SERVICES

Ambulance Services providing local transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured to the nearest facility when such facility is the closest institution that can provide Covered Services appropriate to the Insured's condition. If there is no facility in the local area that can provide Covered Services appropriate to the Insured's condition, Ambulance Services means transportation to the closest facility outside the local area that can provide the necessary service.

Benefits for ambulance services shall be covered only when the service is medically necessary and shall not exceed \$500 per service.

K. REHABILITATION CARE

1. 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.
2. Rehabilitation Care is subject to the Precertification guidelines of this Contract. Failure to comply with these guidelines will result in a 20% reduction in Benefits for Rehabilitation Care.
3. No Benefits are payable:
 - a. after the Insured has reached the maximum level of recovery possible for his or her particular condition and no longer requires definitive treatment other than routine supportive care;
 - b. when confinement in the Rehabilitation Care Facility is intended solely to assist the Insured with the activities of daily living or to provide an institutional environment for the convenience of an Insured.

L. SKILLED NURSING FACILITY SERVICES

1. Hospital Services provided to an Inpatient of a Plan-approved Skilled Nursing Facility.
2. Skilled Nursing Facility Services are limited to 180 days of Inpatient care per Benefit Period.

3. Skilled Nursing Facility Services are subject to the Precertification guidelines of this Contract. Failure to comply with these guidelines will result in a 20% reduction in Benefits for Skilled Nursing Facility Services.
4. No Benefits are payable:
 - a. after the Insured has reached the maximum level of recovery possible for his or her particular condition and no longer requires definitive treatment other than routine supportive care;
 - b. when confinement in a Skilled Nursing Facility is intended solely to assist the Insured with the activities of daily living or to provide an institutional environment for the convenience of an Insured.

M. HOME HEALTH CARE SERVICES

1. The following services provided to an essentially homebound Insured by a Hospital program for Home Health Care or Community Home Health Care Agency, provided such program or agency is Plan approved and the care is prescribed by a Physician.
 - a. Medical and surgical supplies provided by the Home Health Care Provider,
 - b. Prescribed drugs provided through home health care are subject to the same benefit level as other home health care services;
 - c. Oxygen and its administration;
 - d. Professional services of an RN, LPN, or L VN;
 - e. Medical social service consultations;
 - f. Health aide services to an Insured who is receiving covered nursing or Therapy Services.
 - g. Physical therapy, occupational therapy, and speech therapy;
 - h. Dialysis.
2. No Home Health Care Benefits will be provided for:
 - a. Dietitian services;
 - b. Homemaker services;
 - c. Maintenance therapy;
 - d. Durable Medical Equipment;
 - e. Purchase or rental of dialysis equipment;
 - f. Food or home-delivered meals.

Benefits for home health care will be limited to the lesser of 60 visits or \$5,000 per Benefit Period. All Home Health Care Services are subject to the precertification guidelines of this Contract. Failure to comply with the guidelines of this Contract will result in a 20% reduction in benefits for Home Health Care Services.

N. HOSPICE SERVICES

1. The following services will be provided to a terminally ill Covered Person (one who has an Illness not responsive to treatment and who is expected to live less than six months as a result of that Illness):
 - a. room and board in a Hospice facility (either freestanding or affiliated with a Hospital), if Hospice care is being rendered somewhere other than the home;
 - b. nursing, home health aid or counseling services (including bereavement counseling if not provided by volunteers);
 - c. up to seven days of respite care (a Hospital stay for the patient while family members take a break from home care);
 - d. Physical Therapy, Respiratory Therapy or Speech Therapy;
 - e. ambulance services between the patient's home and the Hospice facility;
 - f. and other necessary services such as medical supplies, medicines, drugs, Physician's services, and rental or purchase of Durable Medical Equipment.

Hospice Services are subject to the lifetime maximum of \$10,000 and will be subject to the Precertification guidelines of this Plan. Failure to comply with the Precertification guidelines will result in a 20% reduction in Benefits for Hospice Services.

O. ORAL SURGERY SERVICES

Oral Surgery services for the removal of partially or completely erupted or impacted teeth and Oral Surgery with respect to the tissues of the mouth when not performed in connection with the extraction or repair of teeth.

P. PRESCRIPTION DRUGS

Insulin, Prescription Drugs, and compounded medications administered in a physician's office or in a hospital or outpatient facility. Prescription Drugs prescribed and used for cosmetic purposes are not covered.

For outpatient retail covered prescription drugs refer to the MaxCare prescription drug policy in section 7 of this Contract.

Q. DURABLE MEDICAL EQUIPMENT

1. The rental (or, at the Plan's option, purchase, if it will be less expensive) of Durable Medical Equipment (such as respirators and oxygen tents) including replacement, repair and adjustment of purchased equipment, provided such equipment is prescribed by a Physician and Medically Necessary for the Insured's therapeutic use. Also covered are wheelchairs, hospital beds, crutches, and other items determined by the Plan to be Durable Medical Equipment, but not including disposable items or supplies, except as specified in paragraph O.
2. Benefits will be limited to the lesser of the rental costs or the actual purchase cost of the piece of equipment, as determined by the Plan.

R. DIABETES TREATMENT

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. Diabetes treatment, including self-management training, must be conducted in accordance with the standards developed by the Oklahoma State Board of Health.

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

S. PROSTHETIC APPLIANCES

Devices, along with pertinent supplies, which replace all or part of an absent body organ and which are Medically Necessary for the alleviation or correction of conditions arising out of bodily injury or illness covered by this Contract. Eyeglass lens, soft lens and contact lens shall be included in this provision only if prescribed as part of postoperative treatment for cataract extraction. Payment for breast prostheses shall be a covered Benefit only when implanted 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 due to changes in the size of the limb being augmented.

T. ELECTIVE STERILIZATION

Benefits for elective sterilization are limited to the lesser of the network allowance or \$1,000 for tubal ligation or vasectomy.

U. RECONSTRUCTIVE BREAST SURGERY

Reconstructive breast surgery shall be a covered expense when performed as a result of a partial or total mastectomy. Such reconstructive breast surgery shall include coverage for all stages of reconstructive breast surgery performed on a diseased breast to establish symmetry with a non-diseased breast when reconstructive surgery on the diseased breast is performed, provided that the reconstructive surgery and any adjustments made to the non-diseased breast must occur within twenty-four (24) months of reconstruction of the diseased breast.

V. AUDIOLOGICAL SERVICES

The Contract shall provide coverage for audiological services and hearing aids, limited to:

1. one hearing aid per ear every 48 months for Insureds up to age 18; and
2. up to four additional ear molds per Benefit Period for Insureds up to two years of age.

Hearing aids must be prescribed, fitted and dispensed by a licensed audiologist. The coverage shall be subject to the deductible and coinsurance provisions of the Contract.

W. PROSTATE SCREENING

Covered Expenses shall include one screening per year for the early detection of prostate cancer in men over the age of 50 years, and one screening per year for men over the age of 40 years, who are in high risk categories. The coverage shall not be subject to Contract deductibles. The coverage shall not exceed:

The actual cost of the prostate cancer screening up to a maximum of Sixty-five Dollars, \$65.00, per screening. Prostate Cancer screening coverage shall be offered as follows:

1. The screening shall be performed by a qualified medical professional including, but not limited to, a urologist, internist, general practitioner, doctor of osteopathy, nurse practitioner or physician assistant;
2. The screening shall consist, at a minimum, of the following tests:
 - a. a prostate-specific antigen blood test; and
 - b. a digital rectal examination.

X. SPECIAL ANESTHESIA EXPENSES

Covered Expenses shall include anesthesia expenses, including anesthesia practitioner expenses for the administration of the anesthesia, and hospital and ambulatory surgical center expenses associated with any medically necessary dental procedure when provided to a covered person who is:

1. Severely disabled; or
2. A minor eight (8) years of age or under, and who has a medical or emotional condition which requires hospitalization or general anesthesia for dental care.
 - a. We may require prior authorization in the same manner as that which is required for other conditions and
 - b. Coverage will be subject to the same deductible, copay, coinsurance etc., provisions as other conditions.

Y. WIGS OR SCALP PROSTHESES

Coverage for wigs and scalp prostheses for Insureds who are or have been undergoing chemotherapy or radiation therapy. The coverage shall be subject to the deductible and coinsurance/copayment limits and shall not exceed One hundred fifty Dollars (\$150.00) annually.

Z. MEDICAL / SURGICAL SUPPLIES as defined by the Plan.

AA. BONE DENSITY TESTING

The Contract shall provide coverage for bone density testing when ordered or performed by a Physician or other Provider, limited to one screening per Benefit Period for:

1. females age 45 or older, or
2. females under age 45 who:
 - a. have an estrogen hormone deficiency with:
 - 1) vertebral abnormalities;
 - 2) primary hyperparathyroidism; or
 - 3) a history of fragility bone fractures;
 - b. are receiving long-term glucocorticoid; or
 - c. are currently under treatment for osteoporosis.

Benefits shall be subject to the deductible and coinsurance, and shall be limited to \$150 for each bone density test.

BB. WELL WOMAN EXAMINATIONS

The Contract shall provide coverage for routine gynecological/obstetrical examinations and Pap smear performed in the Physician's office. Benefits shall be subject to the deductible and coinsurance and shall be limited to once each Benefit Period.

CC. COLORECTAL CANCER SCREENING

The Contract shall provide coverage for annual colorectal cancer examination and laboratory tests for any non-symptomatic Insured, in accordance with standard, accepted published medical practice guidelines for colorectal cancer screening, which is:

1. At least 50 years of age; or
2. Less than 50 years of age and at high risk for colorectal cancer according to the standard, accepted published medical practice guidelines.

Benefits shall be subject to the deductible and coinsurance provisions of the Contract.

SECTION VI – EXCLUSIONS

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

- A. Except as specifically provided in this Contract, no Benefits will be provided for services, supplies or charges:
1. Which are not prescribed by or performed by or upon the direction of a Physician or other Provider.
 2. Which the Plan determines are not Medically Necessary.
 3. Rendered by other than Hospitals, Physicians, or other Providers.
 4. Which are in excess of the Allowable Charge, as determined by the Plan.
 5. Which the Plan determines is Experimental/Investigational in nature, except as part of an FDA-approved clinical trial.
 6. 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 the Insured claims the benefits or compensation.
 - a. Each Insured agrees to:
 - 1) pursue his or her rights under the workers' compensation laws;
 - 2) take no action prejudicing the rights and interests of the Plan; and
 - 3) cooperate and furnish such information and assistance the Plan requires to facilitate enforcement of its rights.
 - b. If the Insured receives any money in settlement of the employer's liability, regardless of how the settlement is structured or which items of damages are included, the Insured agrees to:
 - 1) hold in trust said money 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
 - 2) repay the Plan any money recovered from the employer or insurance carrier.
 7. For any condition, disease, ailment, injury or Diagnostic Service to the extent that benefits are provided, or would have been provided had the Insured enrolled, applied for or maintained eligibility for such benefits under Medicare, including any amendments thereto, or any other tax supported or government program (other than this plan), except where state or federal law requires this Contract to reimburse for or be precedent to the benefits of such tax supported or government program. However, in no event shall the Benefits of this Contract paid under provisions of such law exceed the lesser of the benefits required to be paid by such law and the Benefits hereunder in absence of such tax supported or government program.
 8. For any illness or injury suffered after the Insured's Effective Date as a result of any war, or act of war whether declared or undeclared, when serving in the military or an auxiliary unit thereto.
 9. For which an Insured would have no legal obligation to pay in the absence of this or any similar coverage.

10. Received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust, or similar person or group.
11. For cosmetic Surgery or complications resulting thereof, including Surgery to improve or restore personal appearance, unless:
 - a. needed to repair conditions resulting from an accidental injury which occurs after the Insured's Effective Date; or
 - b. for the improvement of the physiological functioning of a malformed body member, except for services related to Orthognathic Surgery or osteotomy.
 - c. such care and services are incidental to or follow surgery resulting from trauma, infection or other disease of the involved parts.
12. Rendered by a Provider who is a member of the Insured's immediate family.
13. Incurred prior to the Insured's Effective Date.
14. Incurred after the date and time of termination of the Insured's coverage.
15. For personal hygiene and convenience items regardless of whether or not recommended by a Physician or other Provider. Examples include: air conditioners, air purifiers or filters; humidifiers; or physical fitness equipment, including exercise bicycles and treadmills.
16. For telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form.
17. For Custodial Care, sanitaria care, domiciliary care or rest cures.
18. For palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, the treatment of subluxation of the foot, care of corns, flat feet calluses, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet.
19. For eyeglasses or contact lenses and the vision examination for prescribing or fitting them, except for aphakic patients (including lenses required after cataract Surgery) and soft lenses or sclera shells intended for use in the treatment of 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.
20. For eye Surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).
21. For hearing aids, tinnitus maskers, or examinations for the prescription or fitting of hearing aids. 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.
22. For any treatment leading to or in connection with transsexual Surgery.
23. For diagnosis, 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 the Insured's reproductive ability.
24. For treatment of sexual dysfunction.
25. No benefits will be provided for services, supplies or charges in connection with all of the following whether medically necessary or not,
 - a. For Surgical procedures, services or charges related to obesity or weight reduction or any complications arising from such surgery.

- b. For Dietary control programs for obesity or weight reduction, including but not limited to the following: the dietary control program; prescription or non-prescription drugs, or medications such as vitamins (whether to be taken orally or by injection), minerals, appetite suppressants, or nutritional supplements; or any other treatment.
 - 26. For which the Provider of service customarily makes no direct charge to an Insured.
 - 27. Rendered by a Skilled Nursing Facility or Home Health Care Agency which is not a Plan approved Provider.
 - 28. Unless deemed Medically Necessary, for treatment of temporomandibular joint dysfunction, including but not limited to diagnostic procedures, splints, orthodontic/orthopedic appliances, restorations necessary to increase vertical dimension or to restore or maintain functional or centric occlusion, alternation of teeth or jaws, Physical Therapy, and medication and behavioral modification related to conditions of temporomandibular joint syndrome or any other conditions involving the jaw joint, adjacent muscles or nerves, regardless of cause or diagnosis.
 - 29. For or related to transplantation of donor organs, tissues or bone marrow, except as specified under "Human Organ, Tissue and Bone Marrow Transplant Services."
 - 30. Coverage of services provided to individuals other than to the named Insured covered by the plan. This exclusion does not apply to coverage of services provided for a newborn up to 31 days of life.
 - 31. The availability and unavailability of membership in the Oklahoma Temporary High Risk Pool and any benefit through the plan are at all times subject to federal law, regulations, and the agreement between the Oklahoma Health Insurance High Risk Pool Board and the U.S. Department of Health and Human Services, and is dependent on continued availability of federal funding.
 - 32. Elective abortions except in cases of rape or incest, or where the life of the woman would be endangered.
 - 33. For unspecified developmental disorders or autistic disease of childhood, except as specified under "Services Related to Treatment of Autism or Autism Spectrum Disorders".
 - 34. For or related to applied behavior analysis.
 - 35. Which are not specifically named in this Contract as Covered Services.
- B. 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 the Insured's coverage, the Plan will be entitled to recover the amount it has allowed for Benefits under this Contract. The Insured must provide the Plan with all documents it needs to enforce its rights under this provision.
 - C. In spite of other provisions of this Plan to the contrary, no payment shall be made under this plan for any expenses you incur as a result of having engaged in a felony.

SECTION VII - MAXCARE COVERED PRESCRIPTION DRUG BENEFITS

A. COPAYMENTS

1. Non-Maintenance (1-30 Days Supply)

Therapeutic Substitution Opportunity Generic Drugs (TSO): \$5

Generic: \$10

Brand name - Preferred: \$35*

Brand name - Non-Preferred: \$60*

Biotech: \$150

2. Maintenance (31-90 Days Supply)

Therapeutic Substitution Opportunity Generic Drugs (TSO): \$10

Generic: \$30

Brand name - Preferred: \$105*

Brand name - Non-Preferred: \$180*

B. DEDUCTIBLE

ANNUAL \$200

C. OUT-OF-POCKET MAXIMUM

ANNUAL \$1,600*

D. BENEFIT MAXIMUM

LIFETIME \$1,000,000 (combined medical and prescription)

**Copayments for Brand Name drugs that have generic versions available, the member pays the brand copayment plus the difference between generic and brand name ingredient cost. The ingredient cost difference will continue to apply after the annual Out-of-Pocket maximum has been met.*

E. COVERED DRUGS

1. Anaphylaxis Agents (Epipen, Ana-Kit, epinephrine, etc.) – Limited to 2 per Rx.
2. Biotech Medications require prior authorization and are available through a limited network of providers. The current biotech medication list is available at www.maxcarerx.com. Please contact MaxCare customer service for assistance in locating a participating biotech pharmacy provider.
3. Blood Glucose Strips.
4. Compounded medications in which at least one ingredient is a prescription legend drug.
5. Contraceptives, diaphragms.
6. Contraceptives, injections.

7. Contraceptives, oral.
8. Contraceptives, patches.
9. Contraceptives, vaginal (Nuvaring).
10. Glucometers. CGMs are excluded.
11. Influenza medications.
12. Insulin syringes by prescription only - \$0.00 copayments.
13. Insulin.
14. Lancet devices.
15. Lancets.
16. Legend drugs, which under applicable federal and state laws require a prescription by a physician or certain other licensed practitioners.
17. Migraine medications. *See page 3 for Limitations.
18. Ostomy products.
19. Prenatal vitamins, legend products only.
20. Retin-A and like products through age 26.
21. Therapeutic Substitution Opportunity Generic Drugs (TSO). All strengths available at a reduced co-pay.

F. MEMBER PAYS DIFFERENCE (MPD) BRAND NAME EXCEPTIONS

1. Coumadin.
2. Dilantin.
3. Lanoxin.
4. Premarin.
5. Synthroid.

G. THERAPEUTIC SUBSTITUTION OPPORTUNITY GENERIC DRUGS

Therapeutic Substitution Opportunity Generic Drugs (TSO) is a 100% voluntary program where select therapeutic categories have been identified which contain highly utilized brand name medications that have NO generic alternative. However, similar medications in the same therapeutic category which treat the same conditions are available as a generic. Copayments for these select TSO medications will be lower than the standard generic copayments. The plan may add categories to this program at its discretion.

SECTION VIII - MAXCARE PRESCRIPTION DRUG EXCLUSIONS AND LIMITATIONS

A. EXCLUSIONS AND LIMITATIONS

1. *Any quantity of drugs or medicine dispensed which exceed a 30-day supply, when taken in accordance with the directions of the prescriber. **Exceptions** - drugs included on the Maintenance Drug List which may be dispensed in quantities sufficient for a 90-day supply at MaxCare's Retail 90 limited network of providers.
2. Anabolic Steroids.
3. Anti-Obesity drugs and medications for any complications arising from such surgery.
4. Any condition, disease, ailment, injury or Diagnostic Service that would be covered under Medicare.
5. Any medication consumed or administered (in whole or in part) where it is dispensed.
6. Any prescription refills in excess of the number of refills specified by the physician or more than one year after the date of the physician's prescription.
7. Contraceptive materials, contraceptive devices.
8. Cosmetic drugs (Rogaine, bleaching agents, Melanin stimulating agents, etc.).
9. Drugs or medications lawfully obtainable without a prescription from a physician or other practitioner except for Drugs listed under covered drugs (OTC medications).
10. Erectile Dysfunction medications.
11. Illness or injury occurring in the course of employment.
12. Infertility medications.
13. Investigational drugs.
14. Medications that the Plan determines are not Medically Necessary.
15. Prescriptions for Non-FDA Approved Indications.
16. Smoking Cessation products.
17. Therapeutic devices or appliances, including support garments and other non-medical substances regardless of their intended uses.
18. Unit Dose Packaged Medications. **Exceptions:** Drugs that would otherwise be covered by plan that are only available in unit-dose packaging.
19. Vitamins with and without fluoride.

B. MIGRAINE/PAIN LIMITATIONS

1. Amerge 1mg tablets No more than 18 tablets within 30 days.
2. Amerge 2.5mg tablets No more than 18 tablets within 30 days.
3. Axert 12.5mg Tablets No more than 12 tablets within 30 days.
4. Axert 6.25mg Tablets No more than 12 tablets within 30 days.
5. Duragesic 100mcg/hr patches No more than 3 boxes within 30 days.
6. Duragesic 12.5mcg/hr patches No more than 3 boxes within 30 days.

7. Duragesic 25mcg/hr patches No more than 3 boxes within 30 days.
8. Duragesic 50mcg/hr patches No more than 3 boxes within 30 days.
9. Duragesic 75mcg/hr patches No more than 3 boxes within 30 days.
10. Frova 2.5mg tablets No more than 18 tablets within 30 days.
11. Imitrex 100mg tablets No more than 18 tablets within 30 days.
12. Imitrex 20mg Nasal Spray No more than 6mls within 30 days.
13. Imitrex 25mg tablets No more than 27 tablets within 30 days.
14. Imitrex 50mg tablets No more than 27 tablets within 30 days.
15. Imitrex 5mg Nasal Spray No more than 6mls within 30 days.
16. Imitrex 6mg/0.5ml Kit/Refill No more than 3 kits within 30 days.
17. Imitrex 6mg/0.5ml Vial No more than six single dose vials within 30 days.
18. Maxalt 10mg tablets No more than 12 tablets within 30 days.
19. Maxalt 5mg tablets No more than 24 tablets within 30 days.
20. Maxalt MLT 10mg tablets No more than 12 tablets within 30 days.
21. Maxalt MLT 5mg tablets No more than 24 tablets within 30 days.
22. Relpax 20mg tablets. No more than 12 tablets within 30 days.
23. Relpax 40mg tablets. No more than 12 tablets within 30 days.
24. Stadol/Butorphanol Nasal Spray No more than two 2.5ml vials within 30 days.
25. Toradol/Ketorolac 10mg tablets No more than 40mg per 24 hours for 5 days only within 30 days.
26. Zomig 2.5mg tablets No more than 18 tablets within 30 days.
27. Zomig 5mg Nasal Spray No more than 6mls within 30 days.
28. Zomig 5mg tablets No more than 12 tablets within 30 days.
29. Zomig ZMT 2.5mg tablets No more than 18 tablets within 30 days.
30. Zomig ZMT 5mg tablets No more than 12 tablets within 30 days.

SECTION IX – GENERAL PROVISIONS

This section explains:

- When your premiums for coverage must be paid;
- Deadline for claims filing;
- How Benefits are determined and how payment is made;
- How Benefits are affected when you have coverage through a government program or you are injured by a third party;
- Your responsibilities under this Contract;

A. ENTIRE CONTRACT; CHANGES

This Contract with the Application and the Identification Card is the entire Contract between the Insured and the Plan. No change in this Contract will be effective until approved by an authorized Plan officer. This approval must be noted on or attached to this Contract. No agent or representative of the Plan other than a Plan officer may otherwise change this Contract or waive any of its provisions. All statements made by the Insured or by any individual Insured shall, in the absence of fraud, be deemed representations and not warranties, and no such statement shall be used in defense to a claim under this Contract, unless it is contained in a written application.

B. BENEFITS TO WHICH INSUREDS ARE ENTITLED

1. The liability of the Plan is limited to the Benefits for Covered Services specified in this Contract.
2. No person other than an Insured is entitled to receive Benefits under this Contract. Such right to Benefits and coverage is not transferable.
3. Benefits for Covered Services specified in this Contract will be provided only for services and supplies that are rendered by a Provider specified in the Definitions section of this Contract and regularly included in such Provider's charges.

C. DEDUCTIBLE

The Deductible is shown in the Schedule.

D. RECORDS OF INSURED ELIGIBILITY AND CHANGES IN INSURED ELIGIBILITY

1. The Insured must furnish the Plan with any data required by the Plan for coverage of Insureds under this Contract. In addition, the Insured must provide prompt notification to the Plan of the effective date of any changes in an Insured's coverage status under this Contract.
2. All notification by the Insured to the Plan must be furnished on forms approved by the Plan. The notification must include all information reasonably required by the Plan to effect changes.

E. PREMIUMS AND CONTRACT CHANGES

1. The amount of premiums shall be the amount determined by the Board for the Benefits of this Contract, as filed with the Insurance Commissioner of the State of Oklahoma.
2. The Board may change premiums upon reasonable notice to the Insured.
3. The Board is authorized to determine, and in its discretion, to alter the Benefits provided by this Contract or payment of premiums thereof. Any such changes shall not affect any Insured

4. All premiums for coverage shall be paid to the Plan and shall be payable on or before each Insured's Effective Date. All further premiums shall be due and payable in advance of and no later than the due date for the coverage period as stated in the periodic Insured billing notice.
5. Failure of the Insured to submit premiums or other payment required by this Contract to the Plan on or before the due date described above shall automatically and without notice terminate and cancel coverage for all Insureds at the end of the grace period for which premiums are paid. The Plan shall have no liability for any care and services, occurring after the date of such termination and cancellation, except as described in "Benefits After Termination of Coverage". The Board reserves the right to reinstate coverage for the Insured upon such terms and conditions as the Plan determines to be acceptable.
6. Coverage under this Contract is renewable at expiration of any coverage period for an additional coverage period at the option of the Plan by its acceptance of any premiums determined to be due and payable. For purposes of this Contract, the coverage period is that period of time covered by the periodic Insured billing notice, as mutually established by the Plan and the Insured.

F. NOTICE AND PROOF OF LOSS

1. Upon receipt of written notice, the Plan will furnish to the Insured forms for filing Proof of Loss. If the forms are not furnished within 15 days after the Plan receives such notice, the Insured will be deemed to have complied with the requirements for filing Proof of Loss upon submitting, within the time fixed for filing such proof, written proof covering the occurrence, character and extent of loss for which the claim is made.
2. Proof of Loss for which claim is made should be submitted promptly. The deadline for submitting a Proof of Loss for any benefits is 12 months following the date of service.

G. RELEASE OF INFORMATION

Each Insured agrees that any person or entity having information relating to an illness or injury for which Benefits are claimed under this Contract may furnish it to the Plan (including copies of records). In addition, the Plan may furnish such information to other entities providing similar benefits at their request.

H. LIMITATION OF ACTIONS

No legal action may be taken to recover Benefits within 60 days after Proof of Loss has been given as specified above, and no such action may be taken later than three years after the expiration of the time within which Proof of Loss is required by this Contract.

I. PAYMENT OF BENEFITS

1. The Plan is authorized by the Insured to make payments directly to Providers furnishing Covered Services for which Benefits are provided under this Contract. However, the Plan reserves the right to make the payments directly to the Insured.
2. The right of an Insured to receive payment is not assignable nor may the Benefits of this Contract be transferred, either before or after Covered Services are rendered.

3. Once Covered Services are rendered by a Provider, the Plan will not honor Insured requests not to pay the claims submitted by the Provider. The Plan will have no liability to any person because of its rejection of the request.
4. For Covered Services provided to an Insured under the Contract, Benefits will be based upon the Allowable Charge for such services, as determined by the Plan.

J. DETERMINATION OF BENEFITS ELIGIBILITY AND UTILIZATION REVIEW

1. The Plan is hereby granted authority to interpret the terms and conditions of this Contract and to determine its Benefits. Such determination by the Plan as to whether care and services rendered to an Insured are eligible for Benefits under this Contract may be made by a panel of Physicians appointed by the Plan at its election.
2. The Plan's medical staff may conduct a medical review of Insured claims to determine that the care and services received were Medically Necessary. In the case of Inpatient claims, the Plan must also determine that the care and services were provided in the most appropriate level of care consistent with the Insured's 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 Contract.

3. To assist the Plan in its review of Insured claims, the Plan may request that:
 - a. the Insured arrange for medical records to be provided to the Plan; and/or
 - b. the Insured submit to a professional evaluation by a Provider selected by the Plan, at the Plan's expense; and/or
 - c. a Physician consultant or panel of Physicians or other Providers appointed by the Plan review the claim.

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

K. INSURED/PROVIDER RELATIONSHIP

1. The choice of a Provider is solely the Insured's.
2. The Plan does not furnish Covered Services but only makes payment for Covered Services received by Insureds. The Plan is not liable for any act or omission of any Provider. The Plan has no responsibility for a Provider's failure or refusal to render Covered Services to an Insured.

L. IDENTIFICATION CARDS

The Plan will provide an Identification Card to each Insured bearing the Insured's name, and identification number.

M. APPLICABLE LAW

This Contract is issued and delivered in the State of Oklahoma, is governed by the laws thereof, is subject to all the terms and provisions set forth in all of the sections hereof, which are fully incorporated into and made a part of this Contract, and is acknowledged by the signed Application of the Insured and signed Acceptance of the Board.

N. INSURED RIGHTS

An Insured shall have no rights or privileges except as specifically provided in this Contract.

O. NOTICE

Any notice required under this Contract must be in writing. Notice given to Board must be sent to the administering insurer. Notice given to you will be sent to your address as it appears on our records. You or the Board may, by written notice, indicate a new address for giving notice.

P. NON-DUPLICATION OF BENEFITS

This Contract will not duplicate benefits which are provided to the Insured under any other Contract, certificate, agreement or policy provided by the Plan or through any other source.

Q. PLAN'S RIGHT OF RECOUPMENT

1. Each Insured agrees to reimburse the Plan for Benefits it has paid and for which the Insured was not eligible under the terms of this Contract. This payment is due and payable immediately upon notification by the Plan. Also, the Plan has the sole right to determine that any overpayments, wrong payments, or any excess payments made under this Contract are an indebtedness which may be recovered by the Plan by deducting it from any future Benefits under this Contract, or under any other coverage provided by the Plan. The Plan's acceptance of premiums or payment of Benefits under this Contract does not waive its rights to enforce these provisions in the future.
2. To the extent the Plan provides or pays Benefits for Covered Services, each Insured agrees to repay the Plan from any money recovered by suit, settlement or otherwise from his or her insurer. Each Insured must do this 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.
3. Each Insured is required to hold in trust for the Plan any money (up to the amount of Benefits paid by the Plan) recovered as described above. Each Insured is required to cooperate and furnish information and assistance which the Plan may require to obtain this reimbursement, including signing legal documents.
4. Failure of the Insured to comply with the above provisions may result in termination of the Insured's coverage and/or legal action to enforce collection.

R. TIME LIMIT ON CERTAIN DEFENSES

After two years from the date of issue of this Contract, no misstatements, except fraudulent misstatements, made by the applicant in the application for such Contract shall be used to void the Contract or to deny a claim for loss Incurred, after the expiration of such two year period.

S. 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 Blue Cross and Blue Shield Insureds 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:

1. The billed charges for your Covered Services; or
2. 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, any other contingent payment at 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 Insured 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 Insured liability calculation methods that differ from the usual BlueCard 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: The Plan may postpone application of your Deductible and/or Coinsurance amounts whenever it is necessary so that we may obtain a Provider discount for you on Covered Services you receive outside the state of Oklahoma.

SECTION X – CLAIMS FILING PROCEDURES

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

A. HOSPITAL CLAIMS

If you are admitted as an Inpatient or receive treatment as an Outpatient in a Hospital which does not file your claims, you should file them as noted below.

B. AMBULATORY SURGICAL FACILITY CLAIMS

If you are treated at a facility which does not file your claims, you should file them as noted below.

C. PHYSICIAN AND OTHER PROVIDER CLAIMS

If you are treated by a Physician or other Provider who does not file your claims, you should file them as noted below.

D. INSURED-FILED CLAIMS

When you must file a claim yourself, send the completed claim to:

Blue Cross and Blue Shield of Oklahoma
P.O. Box 3283
Tulsa, OK 74102-3283
FOR MORE INFORMATION CALL: 877/885-3717

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

1. Full name of patient;
2. Medical service(s) performed;
3. Date of service(s);
4. Who rendered service(s);
5. Charge for service(s);
6. Diagnosis;
7. Provider Tax Identification Number.

Canceled checks, cash register receipts, personal itemizations and statements that show only the balance due are not acceptable. When you file claims, be sure to keep copies of all bills and receipts for your own personal records.

Remember, we must receive your claims for Covered Services within 12 months following the date of service.

E. DIRECT CLAIMS LINE

We have a direct line for claims and inquiries. You may call the following numbers between 8:00 a.m. and 5:00 p.m., Monday through Friday, whenever you have a question concerning a claim or your coverage:

Blue Cross and Blue Shield of Oklahoma
P.O. Box 3283 Tulsa, OK 74102-3283
877/885-3717

F. COMPLAINT/APPEAL PROCEDURE

The Board has established the following process to review an Insured's 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 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 the appeal process described below.

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

1. LEVEL I – APPEAL

a. How and When to File an Appeal

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.

b. 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 should include any documentation, including medical records, that you want to become a part of the review file. The Plan Administrator may request further information if necessary.

c. How to File an Appeal of a Precertification Request Involving Urgent Care

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

d. The Appeal Process

1) Appeal Involving a Non-Urgent Request or Claim

The Plan Administrator's Benefits Administration staff will review your appeal, unless it involves medical judgment. Appeals that require medical judgment are reviewed by a Medical Director of the Plan Administrator. In deciding an appeal 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, the Plan Administrator may consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

- a) In the case of an appeal involving a non-urgent Precertification request, the Plan Administrator will provide a written response to you no later than 30 days following the date they receive your appeal.
- b) In the case of an appeal involving a claim other than a Precertification request, the Plan Administrator will provide a written response to you no later than 60 days following the date we receive your appeal.

2) Appeal of a Precertification Request Involving Urgent Care

A "Precertification Request Involving Urgent Care" will be reviewed by a Medical Director of the Plan Administrator. In deciding an appeal 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, the Plan Administrator may consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

The Plan Administrator will respond to you no later than 72 hours after receipt of your appeal request.

NOTE: The Plan 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.

2. LEVEL II – VOLUNTARY RECONSIDERATION PROCESS

After exhaustion of the appeals process outlined above, you may elect to submit your Benefit dispute to the Plan Administrator for reconsideration. The Plan Administrator will provide you with information necessary to make an informed judgment about the Plan's voluntary review process.

The Plan will not charge you any fees or costs as a part of the voluntary review process. If you elect to pursue your voluntary review rights, any statute of limitations or other defense based on timeliness will be tolled during the time that any voluntary review is pending.

The Plan cannot claim that you failed to exhaust the administrative remedies available to you for failing to submit the Benefit dispute to the Plan's voluntary review process. To request a Level II reconsideration of your Benefit determination, you should 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 should include any documentation, including medical records, that you want to become a part of the review file. The Plan Administrator may request further information if necessary.

a. Member Participation and Protection Committee Review

Your voluntary review will be directed to the Plan 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 which are not resolved to your satisfaction through the Level I appeal process. This committee is comprised of representatives of functional areas of the Plan Administrator, medical staff, and Insured members who are not employed by the Plan Administrator. The committee's determination will be made within 60 days following receipt of your request, unless, in the Plan Administrator's opinion, additional time is needed to complete the review. In such case, the Plan 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.

b. 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.

3. LEVEL III – ADDITIONAL RIGHTS

For services that are denied as not Medically Necessary, medically appropriate, or medically effective, Oklahoma law gives you the right to an external review by an independent review organization. If requested, the Plan Administrator will notify you, in writing, of the procedure to obtain an external review as set forth in the Oklahoma Managed Care External Review Act.

Please keep in mind that you are not obligated to pursue Levels II or III voluntary reviews, before bringing a civil action. If these review processes do not provide a satisfactory resolution to your claim for Benefits, legal remedies are available, including pursuing your claim in court.