



# BlueCross BlueShield of Oklahoma

1400 South Boston • P. O. Box 3283 • Tulsa, OK 74102-3283

## INDIVIDUAL PPO CONTRACT COMPREHENSIVE HEALTH CARE SERVICES BENEFITS

YOU, THE MEMBER, HAVE THE RIGHT TO RETURN THIS CONTRACT FOR ANY REASON WITHIN 10 DAYS OF ITS DELIVERY AND HAVE ANY PAID PREMIUMS REFUNDED. If we do not return your premiums within 30 days from the date of cancellation, we must pay you interest on the proceeds. The interest we pay will be the same rate of interest as the average United States Treasury Bill rate of the preceding Calendar Year, as certified to the State Insurance Commissioner by the State Treasurer on the first regular business day in January of each year, plus two percentage points which shall accrue from the date of cancellation until the premiums are returned. In such event, the Contract shall be deemed to have been cancelled on the date the Contract was placed in the United States mail in a properly addressed, postpaid envelope; or if not so posted, on the date of delivery of such Contract to us. **If you return the Contract, we will have no liability for any health care or service which you have received.**

THIS IS YOUR CONTRACT OF HEALTH CARE AND SERVICES BENEFITS PROVIDED TO YOU BY BLUE CROSS AND BLUE SHIELD OF OKLAHOMA. PLEASE READ IT NOW, AS IT IS VALUABLE IN ASSISTING YOU TO FULLY UNDERSTAND YOUR BENEFITS.

IN THIS CONTRACT, "WE", "US", "OUR" AND THE "PLAN" MEAN BLUE CROSS AND BLUE SHIELD of OKLAHOMA. COVERED PERSONS ARE CALLED "SUBSCRIBERS", "YOU", OR "YOUR".

YOU ARE ELIGIBLE FOR COVERAGE UNDER THIS CONTRACT IF YOU ARE A MEMBER, AS DEFINED. YOUR DEPENDENTS, AS DEFINED, ARE ALSO ELIGIBLE PROVIDED YOU ARE COVERED.

COVERAGE UNDER THIS CONTRACT WILL CONTINUE IN FORCE AT THE OPTION OF YOU, THE MEMBER. HOWEVER, THE PLAN MAY NON-RENEW OR DISCONTINUE COVERAGE FOR YOU AND YOUR DEPENDENTS FOR THE FOLLOWING REASONS:

- FRAUD OR INTENTIONAL MISREPRESENTATION OF A MATERIAL FACT;
- TERMINATION OF THE PARTICULAR TYPE OF COVERAGE, OR ALL COVERAGE, IN THE INDIVIDUAL MARKET; OR
- RELOCATION OUTSIDE THE GEOGRAPHIC AREA ("NETWORK SERVICE AREA") DESIGNATED BY THE PLAN.

**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.**

A Division of Health Care Service Corporation,  
a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association,  
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THIS CONTRACT MAY NOT BE CANCELLED BY YOU OR THE PLAN DURING A COVERAGE PERIOD, EXCEPT FOR NON-PAYMENT OF PREMIUMS, OR FOR FRAUD OR INTENTIONAL MISREPRESENTATION OF A MATERIAL FACT MADE IN ANY STATEMENT, APPLICATION, CLAIM OR OTHER FORM SUBMITTED TO OBTAIN THIS CONTRACT OR ANY OF ITS BENEFITS.

THE COVERAGE PERIOD IS THE PERIOD OF TIME COVERED BY YOUR MEMBER BILLING NOTICE, WHICH WAS ESTABLISHED AT THE BEGINNING OF YOUR FIRST COVERAGE PERIOD UNDER THIS CONTRACT.

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

Keep your health care protection. Please notify the Plan of any change in your address. You should also notify the Plan immediately if you become eligible to enroll for group health coverage.

If you move to an area serviced by another Blue Cross and Blue Shield Plan, you may transfer to the Blue Cross and Blue Shield Plan serving that area. Your coverage may be different from the coverage provided by this Contract.

Upon change of your marital status, either by marriage or divorce, the Plan must receive your written notification within 60 days. Upon your death, a surviving Subscriber should provide written notification to the Plan within 60 days in order that his/her membership rights may be continued.

In corresponding with the Plan, always refer to your identification number which appears on your Identification Card.

GENERAL: In consideration of the membership application and payment of premiums by the Member covered hereunder, Blue Cross and Blue Shield of Oklahoma (the Plan) agrees to make available to the Member, and any eligible Subscriber hereunder, a prepaid program of health care Benefits, subject to and administered in accordance with this Contract. The whole Contract herein consists of the membership application, the Identification Card and this Contract, including any provisions which may be added by Amendment or Endorsement. Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

The issuance of this Contract to you certifies that the Plan has accepted your application and that you, the Member named in the Identification Card, and your Dependents, if any, listed in your application or any supplemental application, along with any exhibits, appendices, addenda and/or other required information accepted by the Plan, as appropriate, are entitled to the Benefits set forth in this Contract.

THIS CONTRACT SETS FORTH A PROGRAM OF COMPREHENSIVE HEALTH CARE BENEFITS FOR INDIVIDUALS WHO HAVE MET THE PLAN'S ELIGIBILITY REQUIREMENTS FOR COVERAGE. THE BENEFITS DESCRIBED IN THIS CONTRACT WILL BE PROVIDED TO YOU OR IN YOUR BEHALF. IF YOU WERE A MEMBER OF THE PLAN ON THE DAY BEFORE THIS CONTRACT BECAME EFFECTIVE, YOUR COVERAGE WILL BE CONTINUOUS.



Blue Cross and Blue Shield of Oklahoma

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Sample

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## *Important Information*

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

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

### **YOUR PARTICIPATING PROVIDER NETWORK**

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

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

### **HOW YOUR COVERAGE WORKS**

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

Your coverage operates around a group of Hospitals, Physicians and other Providers who have agreed to charge no more than a reasonable, predetermined fee for their services. When Subscribers use these Network Providers, they will have less out-of-pocket expense.

**In contrast, when care is received from a Provider who is not a Network Provider, higher Deductibles, Copayments and/or Coinsurance amounts may apply to your coverage. Refer to the *Schedule of Benefits* in the front of this Contract for additional details regarding your Benefits.**

Through other network contracts with Blue Cross and Blue Shield of Oklahoma, many Oklahoma Hospitals, Physicians, and other Providers outside your network have also agreed to work together to help hold the line on health care cost increases. Although your Benefits will be reduced when you do not use Network Providers, using another contracting Provider offers some of the same advantages available to you within your Provider network:

- The Provider will file your claims for you (just as a Network Provider would do).
- Payment for Covered Services will be sent directly to the Provider.
- These Providers have agreed to charge Plan Subscribers no more than a “Maximum Reimbursement Allowance” for Covered Services. If your Provider charges more than our Allowable Charge for Covered Services, you are not responsible for the difference. **However, you will be responsible for the difference, if any, between the contracting Provider’s Allowable Charge and the “Allowable Charge” which a Network Provider would have accepted for the same services.**

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

## SELECTING A PROVIDER

A listing of Oklahoma Network Providers is available on-line through the Blue Cross and Blue Shield of Oklahoma Web site at [www.bcbsok.com](http://www.bcbsok.com). You may also call a Customer Service Representative for assistance in locating a Network Provider. Simply call the toll-free number shown on your Identification Card.

Remember that you receive the highest level of Benefits under this Contract when you use a Network Provider.

## THE BLUECARD® PROGRAM

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

- **Finding a PPO Physician or Hospital**

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

- **Available Care Coast to Coast**

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

- **Remember to Always Carry the BlueCard**

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

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

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

### HOW THE BLUECARD PROGRAM WORKS

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

### YOUR PRESCRIPTION DRUG PROGRAM

To receive the highest level of Benefits, always have your prescriptions filled by a Participating Pharmacy.

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

### HOW YOUR PRESCRIPTION DRUG PROGRAM WORKS

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

**NOTE: Prescription Drugs must be listed on the Drug List to be covered under this Contract, unless coverage is specifically provided elsewhere in this Contract and/or is required by applicable law or regulation. Please refer to the Plan's Web site at [www.bcbsok.com](http://www.bcbsok.com) for a list of Covered Drugs.**

**REMEMBER** — Using Participating Pharmacies can save you time and money. If you have any questions about your Prescription Drug coverage, please call a Customer Service Representative at the number shown on your Identification Card.

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



## MEDICAL NECESSITY LIMITATION

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

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

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

## PREAUTHORIZATION

The Plan has designated certain Covered Services which require “Preauthorization” in order for you to receive the maximum Benefits possible under this Contract.

You are responsible for satisfying the requirements for “Preauthorization”. This means that you must request Preauthorization or assure that your Physician, Provider of services, or a family member complies with the **requirements** below. Failure to Preauthorize services may result in a reduction in Benefits as described below under “Failure to Preauthorize”.

If you utilize a Network Provider for Covered Services, that Provider **may** request Preauthorization for the services. However, it is **the Subscriber's** responsibility to assure that the services are Preauthorized before receiving care. You or your Provider may request Preauthorization by calling the Preauthorization number shown on your Identification Card **before** receiving treatment.

- **Preauthorization Process for Inpatient Services**

For an Inpatient facility stay, *you must request Preauthorization 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 different 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 Preauthorization, your Benefits under this Contract will be reduced, as described below under “Failure to Preauthorize”, provided the Plan determines that Benefits are available upon receipt of a claim.** This reduction applies *in addition* to any Benefit reduction associated with your use of an Out-of-Network Provider, if applicable.

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

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- **Preauthorization Process for Inpatient Psychiatric Care Services**

All **Inpatient** services related to treatment of Mental Illness (including severe Mental Illness), drug addiction, substance abuse or alcoholism must be Preauthorized by the Plan.

- **Preauthorization Requests Involving Emergency Care**

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

- **Preauthorization Process for Certain Outpatient Services**

Preauthorization is also required for the following **Outpatient** Psychiatric Care Services:

- Psychological testing;
- Neuropsychological testing;
- Electroconvulsive therapy;
- Intensive Outpatient Treatment;
- Repetitive Transcranial Magnetic Stimulation.

Preauthorization is not required for therapy visits to a Physician or other professional Provider licensed to perform Covered Services under this Contract.

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

- **Response to Preauthorization Requests for Inpatient Services**

The Plan will provide a written response to your Preauthorization request no later than 15 days following the date we receive your request. This period may be extended one time for up to 15 additional days, if we determine that additional time is necessary due to matters beyond our control.

If the Plan determines that additional time is necessary, we will notify you in writing, prior to the expiration of the original 15-day period, that the extension is necessary, along with an explanation of the circumstances requiring the extension of time and the date by which 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 *Preauthorization* within 15 days following receipt of the additional information.

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

- **Response to Preauthorization Requests Involving Inpatient Services for Urgent Care**

A “*Preauthorization Request Involving Inpatient Services for Urgent Care*” is any request for Medical Care or treatment with respect to which the 15-day review period set forth above:

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

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

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

The Plan's response to your “*Preauthorization Request Involving Inpatient Services for 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.

- **Failure to Preauthorize**

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

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

- The Plan will review the Medical Necessity of the treatment or service prior to the final Benefit determination;
- If the Plan determines the treatment or service is not Medically Necessary or is Experimental, Investigational and/or Unproven, Benefits will be reduced or denied.

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

## **CONCURRENT REVIEW**

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

## **ALLOWABLE CHARGE**

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

- Network and BlueCard Providers have agreed to hold the line on health care costs by providing special prices for our Subscribers. These Providers will accept this negotiated price (called the “**Allowable Charge**”) as payment for Covered Services. This means that, if a Network Provider bills you more than the Allowable Charge for Covered Services, ***you are not responsible for the difference.***
- The Plan will calculate your Benefits based on this “Allowable Charge”. We will deduct any charges for services which are not eligible under your coverage, then subtract any Deductibles, Copayments and/or

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Coinsurance amounts which may be applicable to your Covered Services. We will then determine your Benefits under this Contract, and direct any payment to your Network Provider.

**REMEMBER ...**

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

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

- The Allowable Charge for Non-Contracting Providers for Covered Services will be the lesser of:
  1. the Provider's billed charges; or
  2. the Plan's Non-Contracting Allowable Charge.

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

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

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

- Notwithstanding anything in this Contract to the contrary, for Out-of-Network Emergency Care Services rendered by Non-Contracting Providers, the Allowable Charge shall be equal to the greatest of the following three possible amounts—not to exceed billed charges:
  1. the median amount negotiated with network or contracting Providers for the Emergency Care Services furnished;
  2. the amount for the Emergency Care Services calculated using the same method the Plan generally uses to determine payments for Out-of-Network Provider services, but substituting the in-network or contracting cost-sharing provisions for the Out-of-Network or non-contracting Provider cost sharing provisions; or
  3. the amount that would be paid under Medicare for the Emergency Care Services.

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

- When Covered Services are received outside the state of Oklahoma from a Provider who does not have a written agreement with Blue Cross and Blue Shield of Oklahoma or with the local Blue Cross and Blue Shield Plan, the “Allowable Charge” may be determined by the Blue Cross and Blue Shield Plan (Host Plan) servicing the area. Please refer to “Out-of-Area Services” in the *General Provisions* section for additional information.

**Whenever services are received from an Out-of-Network Provider, you will be responsible for the following:**

- Charges for any services which are not covered under your Plan.
- Any Deductible, Copayment and/or Coinsurance amounts that are applicable to your coverage.
- The difference, if any, between your Provider's billed charges and the Allowable Charge determined by the Host Plan.

## **AMENDMENTS**

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

Because of changes in federal or state laws, or changes in your coverage, provisions called amendments may be added to your Contract.

Be sure to check for an amendment. It amends provisions or Benefits in your Contract.

## **IDENTIFICATION CARD**

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

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

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

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

## **DESIGNATING AN AUTHORIZED REPRESENTATIVE**

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

## **QUESTIONS**

You usually will be able to answer your health care Benefit questions by referring to this Contract. If you need more help, please call a Customer Service Representative at the number shown on your Identification Card.

Or, you can write to us at one of the following addresses:

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**For Claims Submission**

Blue Cross and Blue Shield of Oklahoma  
P.O. Box 3235  
Naperville, IL 60566 – 7235

**Member Complaints/Appeals**

Appeal Coordinator – Customer Service Department  
Blue Cross and Blue Shield of Oklahoma  
P.O. Box 3235  
Naperville, IL 60566-7235

**For Other Inquiries/Correspondence**

Blue Cross and Blue Shield of Oklahoma  
P.O. Box 3239  
Naperville, IL 60566-7239

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

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

Sample

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## *Eligibility, Enrollment, Changes & Termination*

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This section tells:

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

### **WHO IS AN ELIGIBLE PERSON**

Oklahoma Residents under age 65 on their Effective Date who reside or live in the geographic area (“Network Service Area”) designated by the Plan, and who meet the eligibility requirements stated in the application as determined by the Plan, are eligible to apply for coverage under this Contract. A Subscriber may contact the Customer Service Department at the number shown on their Identification Card or access the Web site at [www.bcbsok.com](http://www.bcbsok.com) to determine if he/she is in the Network Service Area.

The Plan reserves the right to request proof of residency upon initial enrollment and from time to time thereafter as the Plan may require.

### **WHO IS AN ELIGIBLE DEPENDENT**

As a Blue Cross and Blue Shield of Oklahoma Member, you have the option of selecting coverage under your membership for your Dependents, or you may apply for separate coverage in their names. If you elect to include them under your membership, an Eligible Dependent is defined as:

- your spouse or Domestic Partner under age 65 on his/her Effective Date; or
- your Dependent child. Wherever used in this Contract, “Dependent child” means your natural child, a stepchild, an eligible foster child, an adopted child or child Placed for Adoption (including a child for whom you or your spouse/Domestic Partner is a party in a legal action in which the adoption of the child is sought), under 26 years of age, regardless of presence or absence of a child’s financial dependency, residency, student status, employment status, marital status, eligibility for other coverage, or any combination of those factors. A child not listed above who is legally and financially dependent upon you or your spouse/Domestic Partner is also considered a Dependent child under this Contract, provided proof of dependency is provided with the child’s application. A Dependent child who is medically certified as disabled and dependent upon you or your spouse/Domestic Partner is eligible to continue coverage beyond the limiting age, provided the disability began before the child attained the age of 26.

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

The Plan also reserves the right to review a Physician's certificate of disability and/or request medical records or require a medical examination by an independent Physician to verify disability at the Subscriber's expense. The Plan will make the final determination regarding the Dependent’s disability status.

## **CHILD-ONLY COVERAGE**

An Eligible Person who has not attained age 21 prior to their Effective Date may enroll as the sole Subscriber under this Contract. In such event, this Contract is considered child-only coverage and the following restrictions apply:

- Each child is enrolled individually as the sole Subscriber; the parent or legal guardian is not covered and is not eligible for Benefits under this Contract.
- No additional Dependents may be added to the enrolled child's coverage. Each child must be enrolled in his/her own Contract. Note: If a child covered under this Plan acquires a new eligible child of his/her own, the new eligible child may be enrolled in his/her own Contract if application for coverage is made within 60 days of the child's birth.
- If a child is under the age of 18, his/her parent, legal guardian, or other responsible party must submit the application for child-only insurance form, along with any exhibits, appendices, addenda and/or other required information to the Plan, as appropriate. For any child under 18 covered under this Contract, any obligations set forth in this Plan, any exhibits, appendices, addenda and/or other required information will be the obligations of the parent, legal guardian, or other responsible party applying for coverage on the child's behalf. Application for child-only coverage will not be accepted for an adult child that has attained age 21 as of the beginning of the Policy Year. Adult children (at least 18 years of age but no older than 20 years of age) who are applying as the sole Member under this Contract must apply for their own individual Contract and must sign or authorize the application(s).

## **APPLYING FOR COVERAGE**

You may apply for coverage for yourself and/or your Dependents.

No eligibility rules or variations in premium will be imposed based upon your health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or any other health status related factor. You will not be discriminated against for coverage under this Plan on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation. Variations in the administration, processes or Benefits of this Contract that are based on clinically indicated, reasonable medical management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.

You may enroll in or change coverage for yourself and/or your Dependents during one of the following enrollment periods. Your and/or your Dependents' Effective Date will be determined by the Plan, depending upon the date your application is received, payment of the initial premiums no later than the day before the Effective Date, and other determining factors.

The Plan may require acceptable proof (such as copies of legal adoption or legal guardianship papers, or court orders) that an individual qualifies as a Dependent under this Plan.

## **ANNUAL OPEN ENROLLMENT PERIOD/EFFECTIVE DATE OF COVERAGE**

You may apply for or change coverage for yourself and/or your Dependents during the annual open enrollment period.

When you enroll during the annual open enrollment period your and/or your Dependents' Effective Date will be the following January 1<sup>st</sup>, unless otherwise designated by the Plan.

This section "Annual Open Enrollment Period/Effective Date of Coverage" is subject to change by the Plan and/or applicable law, as appropriate.



## **SPECIAL ENROLLMENT PERIODS/EFFECTIVE DATES OF COVERAGE**

Special enrollment periods have been designated during which you may change coverage for yourself and/or your Dependents. You must apply for coverage within 60 days from the date of a special enrollment event.

Except as otherwise provided below, if you apply between the 1<sup>st</sup> day and 15<sup>th</sup> day of the month, your Effective Date will be no later than the 1<sup>st</sup> day of the following month, or if you apply between the 16<sup>th</sup> day and the end of the month, your and/or your Dependents' Effective Date will be the date determined by the Plan.

Special Enrollment Events:

- You experience a loss of Minimum Essential Coverage. New coverage for you and/or your Dependents will be effective no later than the first day of the month following the loss.
- You gain a Dependent or become a Dependent through marriage. New coverage for you and/or your Dependents will be effective no later than the first day of the following month.
- You gain a Dependent through birth, adoption or Placement for Adoption or court-ordered dependent coverage. New coverage for you and/or your Dependents will be effective no later than the date of birth, adoption, or Placement for Adoption.

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

If your membership includes at least *one* Dependent, coverage for a newborn will be effective on the date of birth and continue for 31 days. In order to extend the coverage beyond 31 days, your application to add coverage for the newborn must be received within 31 days following the child's birth; and you must make the required contribution for such coverage from the date of birth.

- Your enrollment or non-enrollment in a Qualified Health Plan ("QHP") is unintentional, inadvertent, or erroneous as evaluated and determined by the Plan.
- You adequately demonstrate that the QHP in which you are enrolled substantially violated a material provision of its contract in relation to you.
- You are determined newly eligible or newly ineligible for Advance Premium Tax Credit or have a change in eligibility for cost-sharing reductions, regardless of whether you are already enrolled in a QHP.
- You gain access to new QHPs as a result of a permanent move.
- You are enrolled in an individual non-calendar year health insurance policy. Your special open enrollment period begins on the date that is 30 calendar days prior to the date the policy year ends.
- Legal separation, divorce, death, or dissolution of a Domestic Partnership.
- Loss of Dependent status, such as attaining the limiting age to be eligible as a Dependent child under this Contract.
- Termination of employment, reduction in the number of hours of employment, or loss of coverage due to a policy no longer offering benefits to the class of similarly situated individuals that includes you and/or your Dependents.
- Loss of coverage through an HMO in the individual market because you and/or your Dependents no longer reside, live or work in the HMO service area.

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- Loss of coverage through an HMO or other arrangement in the group market because you and/or your Dependents no longer reside, live or work in the HMO service area, and no other coverage is available to you and/or your Dependents.
- You incur a claim that would meet or exceed a lifetime limit on all Benefits.
- Your and/or your Dependent's employer ceases to contribute towards the employee's or Dependent's coverage (excluding COBRA continuation coverage).
- COBRA continuation of coverage is exhausted.

Loss of eligibility does not include a loss due to failure of the individual or the participant to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or any intentional misrepresentation of a material fact in connection with the plan).

Your application for special enrollment must be received by the Plan within 60 days following the loss of other coverage. **Coverage under special enrollment will be effective no later than the first day of the month after the Plan receives your application for enrollment for yourself or on behalf of your Dependent(s).**

**Coverage resulting from any of the special enrollment events outlined above is contingent upon timely completion of the application and remittance of the appropriate premiums in accordance with the guidelines as established by the Plan.**

## **CHANGES IN FAMILY MEMBERSHIP**

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

In the event of a divorce, your spouse/Domestic Partner may wish to continue Blue Cross and Blue Shield of Oklahoma coverage. He/she may apply for equal or lesser coverage if his/her application is received by the Plan no later than 60 days after the divorce is granted. Your Dependent children may continue to be eligible under your membership, or your spouse/Domestic Partner may obtain his/her own Dependent coverage.

In the event of your death, your spouse/Domestic Partner and/or Dependent children may wish to continue Blue Cross and Blue Shield of Oklahoma coverage. They may apply for equal or lesser coverage if their application is received by the Plan no later than 60 days after your death.

A Dependent child who attains the age of 26 is no longer eligible under your coverage (unless medically certified as disabled). The Dependent may apply for equal or lesser coverage if his/her application is received by the Plan no later than 31 days after the end of the coverage period coinciding with or following their 26<sup>th</sup> birthday.

If the application for a membership transfer is not received within the time period specified above, enrollment will be permitted during the next annual open enrollment period.

## **NOTIFICATION OF ELIGIBILITY CHANGES**

It is the Subscriber's responsibility to notify the Plan, as appropriate, of any change to a Subscriber's name or address. An address change may result in Benefit changes for you and your Dependents if you move out of the Plan's Network Service Area. You may call Customer Service at the number shown on your Identification Card or log on to the Web site at [www.bcbsok.com](http://www.bcbsok.com).

## **TERMINATION OF COVERAGE/WHEN COVERAGE ENDS**

This Plan does not provide Benefits even if Preauthorization for such services was received from the Plan, that are received after a Member's coverage under this Contract is terminated.

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When a Subscriber is no longer an Eligible Person or Eligible Dependent, coverage stops at the end of the coverage period during which eligibility ceases, except that, when a Subscriber ceases to be an Eligible Dependent by reason of death, coverage for that Subscriber will terminate on the date of death.

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

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

Termination of the Contract automatically ends all of your coverage at the same time and date.

## **WHAT WE WILL PAY FOR AFTER YOUR COVERAGE ENDS**

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

- a period of time equal to the length of time you were covered under the Contract; or
- the duration of the Hospital confinement; or
- 90 days following termination of coverage.

We will have no liability for any Benefits under your Contract for Covered Services which are incurred after your coverage terminates, except as specified above.

## **TRANSFERS OUT OF THE NETWORK SERVICE AREA**

A Member and/or his or her Eligible Dependents, if any, who relocate outside the Network Service Area are no longer eligible for coverage under this Contract. You may contact a Customer Service Representative for other coverage options that are available to you.

## **CONVERSION PRIVILEGE AFTER TERMINATION OF COVERAGE**

If a Subscriber ceases to be eligible under this Contract, he/she may apply for continuous coverage under an Individual Conversion Contract, or under another Blue Cross and Blue Shield of Oklahoma individual Contract, subject to the underwriting and enrollment regulations applicable to the new coverage.

If you move to an area serviced by another Blue Cross and Blue Shield Plan, you may transfer to the Blue Cross and Blue Shield Plan serving that area. *Coverage under this Contract is available only to Oklahoma Residents who reside or live within the Network Service Area.*

When you transfer to an Individual Conversion Contract, or to another individual Contract offered by Blue Cross and Blue Shield of Oklahoma or any another Blue Cross and Blue Shield Plan, your coverage may be different from the coverage provided by this Contract.

**Written application for an Individual Conversion Contract must be received by Blue Cross and Blue Shield of Oklahoma no later than 31 days after you cease to be eligible under this Contract.**

An Individual Conversion Contract will not be available to a Subscriber who:

- is eligible for coverage under a group having a contract with the Plan; or
- is enrolled under an individual Contract through Blue Cross and Blue Shield of Oklahoma or any other Blue Cross and Blue Shield Plan.

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## **DELETING A DEPENDENT**

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

## **WHEN YOU TURN AGE 65**

You may terminate coverage when you turn age 65 when Medicare takes over. You may apply for one of the Medicare supplement coverage options offered by Blue Cross and Blue Shield of Oklahoma.

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

## **REINSTATEMENT**

When coverage lapses for failure to pay premiums for this Contract, the subsequent acceptance of such premium payments by the Plan or its duly authorized agents shall reinstate the Contract. For purposes of this reinstatement provision, mere receipt and/or negotiation of a late premium payment does not constitute acceptance. The reinstated Contract shall cover only loss resulting from accidental injury sustained after the date of reinstatement and loss due to sickness beginning more than 10 days after such date. In all other respects, the Subscriber and the Plan shall have the same rights hereunder as they had under the Contract immediately before the due date of the defaulted premiums, including the right of the Subscriber to apply the period of time this Contract was in effect immediately before the due date of the defaulted premiums toward satisfaction of any waiting periods for Benefits, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium payments accepted in connection with a reinstatement shall be applied to a period for which premiums have not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

## **REINSTATEMENT OF COVERAGE FOLLOWING MILITARY ACTIVATION**

A Subscriber who is an Oklahoma Resident may request reinstatement of coverage under this Contract if the termination of coverage results from the Subscriber's activation for military service, or from the Subscriber's eligibility for a federal government-sponsored health insurance program resulting from such military activation.

Reinstatement shall be granted into the same coverage the Subscriber held prior to termination, in the same rating tier the Subscriber held prior to activation, and subject to the payment of the current premium charged to other persons of the same age and gender that are covered under the same coverage option.

Except for the birth or adoption of a Dependent child that occurs during the period of activation, reinstatement of coverage must be into the same membership type, or a membership type covering fewer persons, as such Subscriber held prior to lapsing the coverage, and at the same or higher Deductible level.

Reinstatement rights are available only if the Subscriber is an Oklahoma Resident who resides or lives in the Network Service Area and provides written notice to the Plan within 31 days following the later of deactivation or loss of coverage under the federal government-sponsored health insurance program. The Plan may request proof of loss and the timing of the loss of such government-funded coverage in order to determine the Subscriber's eligibility for reinstatement. These reinstatement rights shall not be available to any Subscriber if the activated person is discharged from the military under other than honorable conditions.

## **RESCISSION OF COVERAGE**

Any act, practice or omission that constitutes fraud or making an intentional misrepresentation of a material fact with the intent to deceive the Plan on the Member's application, may result in the cancellation of the Member's coverage (and/or coverage of any Dependents), retroactive to the Effective Date, subject to 30 days' prior notification. Rescission is defined as a cancellation or discontinuance of coverage that has a retroactive effect. In the event of such cancellation, the Plan may deduct from the premium refund any amounts made in claim

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payments during this period, and the Member may be liable for any claims payment amount greater than the total amount of premiums paid during the period for which cancellation is affected. At any time when the Plan is entitled to rescind coverage already in force, or is otherwise permitted to make retroactive changes to this Contract, the Plan may at its option make an offer to reform the policy already in force or is otherwise permitted to make retroactive changes to this policy and/or change in the rating category/level. In the event of reformation, the Contract will be reissued retroactive in the form it would have been issued had the misstated or omitted information been known at the time of application. Please refer to the ***Complaint/Appeal Procedures*** section for appeal rights concerning rescission and/or reformation.

Sample

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## Comprehensive Health Care Services

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This section lists the Covered Services under your Contract. **Please note that services must be Medically Necessary, as determined by the Plan, in order to be covered under this Contract.**

### PREVENTIVE CARE SERVICES

Any of the following Covered Services performed by a Provider.

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

1. Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (“USPSTF”);
2. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (“CDC”) with respect to the individual involved;
3. Evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”) for infants, children, and adolescents; and
4. With respect to women, such additional preventive care and screenings, not described in item 1 above, as provided for in comprehensive guidelines supported by the HRSA. Such services will include the following:
  - Breast-feeding Support, Services and Supplies – Benefits will be provided for breast-feeding counseling and support services rendered by a Provider for pregnant and postpartum women. Benefits include the rental (or, at the Plan’s option, the purchase) of manual or electric breast-feeding equipment.
  - Contraceptive Services – Benefits will be provided for the following contraceptive services when prescribed by a licensed Provider for women with reproductive capacity:
    - contraceptive counseling;
    - FDA-approved prescription devices and medications;
    - over-the-counter contraceptives; and
    - sterilization procedures (tubal ligation), but not including hysterectomy.

Coverage includes contraceptives in the following categories:

- progestin-only contraceptives;
- combination contraceptives;
- emergency contraceptives;
- extended-cycle/continuous oral contraceptives;
- cervical caps;
- diaphragms;
- implantable contraceptives;
- intra-uterine devices;
- injectables;
- transdermal contraceptives and
- vaginal contraceptive devices.

**NOTE:** Prescription contraceptive medications are covered under the *Outpatient Prescription Drug Benefits and Related Services* section of this Contract, *if applicable*.

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The contraceptive drugs and devices listed above may change as FDA guidelines are modified. Deductible, Copayment and/or Coinsurance amounts will not apply to FDA-approved contraceptive drugs and devices on the Contraceptive Information list. You may access the Web site at [www.bcbsok.com](http://www.bcbsok.com) or contact Customer Service at the toll-free number on your Identification Card.

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

Covered Preventive Care Services received from Out-of-Network Providers and/or Out-of-Network Pharmacies, or other routine Covered Services not provided for under this provision may be subject to any Deductibles, Copayments, Coinsurance and/or Benefit maximums applicable to your coverage.

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

The Preventive Care Services described in items 1 through 4 above may change as the USPSTF, CDC, and HRSA guidelines are modified. For more information you may access the Web site at [www.bcbsok.com](http://www.bcbsok.com) or contact Customer Service at the toll-free number listed on your Identification Card.

If a recommendation or guideline for a particular Preventive Care Service does not specify the frequency, method, treatment or setting in which it must be provided, the Plan may use reasonable medical management techniques to apply Benefits or determine coverage.

If a covered Preventive Care Service is provided during an office visit and is billed separately from the office visit, you may be responsible for any applicable Deductible, Copayment and/or Coinsurance amounts for the office visit only. If an office visit and the Preventive Care Service are not billed separately and the primary purpose of the visit was not the Preventive Care Service, you may be responsible for any applicable Deductible, Copayment, and/or Coinsurance amounts for the office visit including the Preventive Care Service.

Examples of Covered Services included are (1) routine annual physicals, including immunizations, well-child care, cancer screening mammograms, bone density tests; and screening for prostate cancer and colorectal cancer; (2) smoking cessation counseling services; and (3) healthy diet counseling and obesity screening/counseling.

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

Covered Services *not* included in items 1 through 4 above may be subject to any Deductibles, Copayments, Coinsurance and/or dollar maximums applicable to your coverage.

Covered Preventive Care Services received from Out-of-Network Providers may be subject to any Deductible, Copayment and/or Coinsurance amounts applicable to your coverage.

Coverage for the Preventive Care Services specified in items 1 through 4 above shall be provided in accordance with the terms and conditions of the appropriate Benefit section of this Contract (for example: "Hospital Services", "Surgical/Medical Services", "Outpatient Diagnostic Services" or "Outpatient Prescription Drugs and Related Services".)

## **EMERGENCY CARE SERVICES**

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

- serious jeopardy to the Subscriber's health;
- serious impairment to bodily function; or

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- serious dysfunction of any bodily organ or part.

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

## **HOSPITAL SERVICES**

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

- **Bed and Board**

Bed, board and general nursing service in:

- A room with two or more beds;
- A private room (private room Allowable Charge is equal to the most prevalent semiprivate room charges of your Hospital). Private room charges in excess of the semiprivate room Allowable Charge will not be eligible for Benefits unless the patient is required under the infection control policy of the Hospital to be in isolation to prevent contagion;
- A bed in a Special Care Unit which gives intensive care to the critically ill.

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

- **Ancillary Services**

- Operating, delivery and treatment rooms;
- Prescribed drugs;
- Whole blood, blood processing and administration;
- Anesthesia supplies and services rendered by an employee of the Hospital or other Provider;
- Medical and surgical dressings, supplies, casts and splints;
- Oxygen;
- Subdermally implanted devices or appliances necessary for the improvement of physiological function;
- Diagnostic Services;
- Therapy Services.

- **Emergency Accident Care**

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

- **Emergency Medical Care**

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

- **Surgery**

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

- **Routine Nursery Care**

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

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- Routine Nursery Care does not include treatment or evaluation for medical or surgical reasons during or after the mother's maternity confinement. In the event the newborn requires such treatment or evaluation while covered under this Contract:
  - the infant will be considered as a Subscriber in its own right and will be entitled to the same Benefits as any other Subscriber under this Contract; and
  - a separate Deductible will apply to the newborn's Hospital confinement.

## **SURGICAL/MEDICAL SERVICES**

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

- **Surgery**

Benefits include visits before and after Surgery.

- If an incidental procedure<sup>1</sup> is carried out at the same time as a more complex primary procedure, then Benefits will be available for only the primary procedure. **Separate Benefits will not be available for any incidental procedures performed at the same time.**
- When more than one surgical procedure is performed through more than one route of access during one operation, you are covered for:
  - the primary procedure; plus
  - 50% of the amount available for each of the additional procedures had those procedures been performed alone.
- Sterilization, regardless of Medical Necessity.

- **Assistant Surgeon**

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

- **Anesthesia**

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

- **Inpatient Medical Services**

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

- Inpatient Medical Care Visits

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

- Intensive Medical Care

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

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<sup>1</sup>A procedure performed at the same time as the primary surgical procedure, but which is clinically integral to the performance of the primary procedure, and, is not reimbursed separately.

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

- Consultation

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

- Newborn Well Baby Care

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

- **Outpatient Medical Services**

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

- Emergency Accident Care

Treatment of accidental bodily injuries.

- Emergency Medical Care

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

- Home, Office, and Other Outpatient Visits

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

- Contraceptive Devices

Contraceptive devices which are:

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

- Audiological Services

Audiological services and hearing aids, limited to:

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

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

## **OUTPATIENT DIAGNOSTIC SERVICES**

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

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## OUTPATIENT THERAPY SERVICES

- Radiation Therapy
- Chemotherapy

**Outpatient Therapy Services do not include oral Chemotherapy or self-injectable/self-administered Chemotherapy. These Prescription Drugs may be covered under *Outpatient Prescription Drugs and Related Services*, under this Contract.**

- Respiratory Therapy
- Dialysis Treatment
- Physical Therapy, Occupational Therapy and Speech Therapy

**Benefits for Outpatient Physical Therapy, Outpatient Occupational Therapy and Outpatient Speech Therapy (including visits to the Subscriber's home) are limited to the number of visits specified in the *Schedule of Benefits for Comprehensive Health Care Services*.**

## MATERNITY SERVICES

- Hospital Services and Surgical/Medical Services from a Provider for:
  - Normal Pregnancy  
Normal pregnancy includes any condition usually associated with the management of a difficult pregnancy but not considered a complication of pregnancy.
  - Complications of Pregnancy  
Physical effects directly caused by pregnancy but which are not considered from a medical viewpoint to be the effect of normal pregnancy, including conditions related to ectopic pregnancy or those that require cesarean section.
  - Interruptions of Pregnancy
    - Miscarriage.
    - Abortion, when the life of the mother is endangered.
- Covered Maternity Services include the following:
  - A minimum of 48 hours of Inpatient care at a Hospital, or a birthing center licensed as a Hospital, following a vaginal delivery for the mother and newborn infant who are covered under this Contract after childbirth, except as otherwise provided in this section; or
  - A minimum of 96 hours of Inpatient care at a Hospital following a delivery by cesarean section for the mother and newborn infant who are covered under this Contract after childbirth, except as otherwise provided in this section; and
  - Postpartum home care following a vaginal delivery if childbirth occurs at home or in a birthing center licensed as a birthing center. The coverage shall provide for one home visit within 48 hours of childbirth by a licensed health care Provider whose scope of practice includes providing postpartum care. The visits shall include, at a minimum:
    - physical assessment of the mother and newborn infant;
    - parent education regarding childhood immunizations;
    - training or assistance with breast or bottle feeding; and
    - performance of any Medically Necessary and appropriate clinical tests.

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

- Inpatient care shall include, at a minimum:
  - physical assessment of the mother and newborn infant;
  - parent education regarding childhood immunizations;
  - training or assistance with breast or bottle feeding; and
  - performance of any Medically Necessary and appropriate clinical tests.
- The Plan may provide coverage for a shorter length of Hospital Inpatient stay for services related to maternity/obstetrical and newborn infant care provided:
  - The licensed health care Providers determine that the mother and newborn infant meet medical criteria contained within guidelines, developed by or in cooperation with licensed health care Providers, which recognize treatment standards, including, but not limited to, the most current treatment standards of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, that determine the appropriate length of stay based upon:
    - evaluation of the antepartum, intrapartum, and postpartum course of the mother and newborn infant;
    - the gestational age, birth weight and clinical condition of the newborn infant;
    - the demonstrated ability of the mother to care for the newborn infant postdischarge; and
    - the availability of postdischarge follow-up to verify the condition of the newborn infant in the first 48 hours after delivery; and
  - The Plan covers one home visit, within 48 hours of discharge, by a licensed health care Provider whose scope of practice includes providing postpartum care. Such visits shall include, at a minimum:
    - physical assessment of the mother and newborn infant;
    - parent education regarding childhood immunizations;
    - training or assistance with breast or bottle feeding; and
    - performance of any Medically Necessary and appropriate clinical tests.

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

## **MASTECTOMY AND RECONSTRUCTIVE SURGICAL SERVICES**

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

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

However, coverage may be provided for a shorter length of Hospital Inpatient stay where the attending Physician, in consultation with the patient, determines that a shorter period of Hospital stay is appropriate.

- Coverage for reconstructive breast Surgery performed as a result of a partial or total mastectomy. Covered Services shall consist of the following, when provided in a manner determined in consultation with the attending Physician and the patient:
  - reconstruction of the breast on which the mastectomy has been performed;

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- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and physical complications at all stages of mastectomy, including lymphedemas.

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

## **HUMAN ORGAN, TISSUE AND BONE MARROW TRANSPLANT SERVICES**

**All transplants are subject to Preauthorization and must meet the criteria established by the Plan for assessing and selecting Providers for transplants.**

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

### **• DEFINITIONS**

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

#### **– Bone Marrow Transplant**

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

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

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

#### **– High-Dose Chemotherapy**

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

#### **– High-Dose Radiation Therapy**

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

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– **Preauthorization**

The process that determines in advance the Medical Necessity or Experimental, Investigational or Unproven nature of certain care and services under the Contract. Preauthorization is subject to all conditions, exclusions and limitations of the Contract. Preauthorization does not guarantee that all care and services a Subscriber receives are eligible for Benefits under the Contract.

– **Procurement Services**

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

• **TRANSPLANT SERVICES**

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

- Musculoskeletal transplants;
- Parathyroid transplants;
- Cornea transplants;
- Heart-valve transplants;
- Kidney transplants;
- Heart transplants;
- Single lung, double lung and heart/lung transplants;
- Liver transplants;
- Intestinal transplants;
- Small bowel/liver or multivisceral (abdominal) transplants;
- Pancreas transplants;
- Islet cell transplants; and
- Bone Marrow Transplants.

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

- The transplant must meet the criteria established by the Plan for assessing and performing organ or tissue transplants, or Bone Marrow Transplant procedures, as set forth in the Plan's written medical policies.
- In addition to the Exclusions set forth elsewhere in this Contract, no Benefits will be provided for the following organ or tissue transplants or Bone Marrow Transplants or related services:
  - Adrenal to brain transplants.
  - Allogeneic islet cell transplants.

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- High-Dose Chemotherapy or High-Dose Radiation Therapy if the associated autologous or allogeneic Bone Marrow Transplant, stem cell or progenitor cell treatment or rescue is not a Covered Service.
- Small bowel transplants using a living donor.
- Any organ or tissue transplant or Bone Marrow Transplant from a non-human donor or for the use of non-human organs for extracorporeal support and/or maintenance.
- Any artificial device for transplantation/implantation, except in limited instances as reflected in the Plan's written medical policies.
- Any organ or tissue transplant or Bone Marrow Transplant procedure which the Plan considers to be Experimental, Investigational or Unproven in nature.
- Expenses related to the purchase, evaluation, Procurement Services, or transplant procedure if the organ or tissue or bone marrow or stem cells or progenitor cells are sold rather than donated to the Subscriber recipient.
- All services, provided directly for or relative to any organ or tissue transplant, or Bone Marrow Transplant procedure which is not specifically listed as a Covered Service in this Contract.

• **DONOR BENEFITS**

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

- When both the recipient and the living donor are Subscribers, each is entitled to the Benefits of the Contract.
- When only the recipient is a Subscriber, both the donor and the recipient are entitled to the Benefits of the Contract. The donor Benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage or other Blue Cross or Blue Shield coverage or any government program. Benefits provided to the donor will be applied to the recipient's coverage under the Contract.
- When only the living donor is a Subscriber, the donor is entitled to the Benefits of the Contract. The Benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage or other Blue Cross or Blue Shield coverage or any government program available to the recipient. There are no Covered Services for the non-Subscriber transplant recipient.
- If any organ or tissue or bone marrow or stem cells or progenitor cells are sold rather than donated to the Subscriber recipient, no Covered Services will be provided for the purchase price, evaluation, Procurement Services or procedure.
- The Plan is not liable for transplant expenses incurred by donors, except as specifically provided.

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

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

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

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- The Bone Marrow Transplant is available to the Subscriber seeking it and will be provided within a clinical trial conducted or approved by the **National Institutes of Health**;
- The Bone Marrow Transplant is not available free or at a reduced rate; and
- The Bone Marrow Transplant is not excluded by another provision of the Contract.

## **AMBULATORY SURGICAL FACILITY SERVICES**

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

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

## **SERVICES RELATED TO TREATMENT OF AUTISM AND AUTISM SPECTRUM DISORDERS**

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

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

**Benefits for services related to treatment of autism and autism spectrum disorders are subject to the following limitations:**

- **Subscribers under age six shall be entitled to the Benefits specified in the *Schedule of Benefits for Comprehensive Health Care Services* (included in the front of this Contract) for Physical Therapy, Occupational Therapy and Speech Therapy.**
- **Subscribers age six and older are subject to the limitations specified under "Outpatient Therapy Services", as set forth in the *Comprehensive Health Care Services* section of this Contract.**

## **PSYCHIATRIC CARE SERVICES**

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

- **Inpatient Facility Services**  
Covered Inpatient Hospital Services provided by a Hospital, Psychiatric Hospital, Residential Treatment Center or other Plan-approved Provider.
- **Inpatient Medical Services**  
Covered Inpatient Medical Services provided by a Physician or other Provider:
  - Medical Care visits **limited to one visit or other service per day**;
  - Individual Psychotherapy;
  - Group Psychotherapy;

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- Psychological Testing; and
- Convulsive Therapy Treatment.

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

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

- Outpatient Psychiatric Care Services

- Facility and Medical Services

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

- Day/Night Psychiatric Care Services

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

- Drug Addiction, Substance Abuse and Alcoholism

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

## **AMBULANCE SERVICES**

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

- From your home to a Hospital;
- From the scene of an accident or medical emergency to a Hospital;
- Between Hospitals;
- Between a Hospital and a Skilled Nursing Facility;
- From the Hospital to your home.

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

## **PRIVATE DUTY NURSING SERVICES**

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

**Benefits for Private Duty Nursing Services are limited to the number of visits specified in the *Schedule of Benefits for Comprehensive Health Care Services* in the front of this Contract.**

## **REHABILITATION CARE**

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

**Rehabilitation Care is limited to the number of Inpatient days specified in the *Schedule of Benefits for Comprehensive Health Care Services* in the front of this Contract.**

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

## **SKILLED NURSING FACILITY SERVICES**

Covered Inpatient Hospital Services and supplies rendered to an Inpatient of an eligible Skilled Nursing Facility.

**Skilled Nursing Facility Services are limited to the number of Inpatient days specified in the *Schedule of Benefits for Comprehensive Health Care Services* in the front of this Contract.**

**Skilled Nursing Facility Services are subject to the Preauthorization requirements of this Contract (see “*Important Information*”). Failure to comply with these requirements will result in a \$500 reduction in Benefits for Skilled Nursing Facility Services if, upon receipt of a claim, Benefits are available under this Contract.**

No Benefits are available:

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

## **HOME HEALTH CARE SERVICES**

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

- Medical and surgical supplies;
- Prescribed drugs;
- Oxygen and its administration;
- **Home visits for the following, limited to the number of visits specified in the *Schedule of Benefits for Comprehensive Health Care Services* in the front of this Contract:**
  - Professional services of an RN, LPN, or LVN;
  - Medical social service consultations;
  - Health aide services while you are receiving covered nursing or Therapy Services.
  - Services of a licensed registered dietician or licensed certified nutritionist, when authorized by the patient's supervising Physician and when Medically Necessary as part of diabetes self-management training.

**Home Health Care is subject to the Preauthorization requirements of this Contract (see “*Important Information*”). Failure to comply with these requirements will result in a \$500 reduction in Benefits for Home Health Care if, upon receipt of a claim, Benefits are available under this Contract.**

We do not pay Home Health Care Benefits for:

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

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

## **HOSPICE SERVICES**

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

**Hospice Services are subject to the Preauthorization requirements of this Contract (see “Important Information”). Failure to comply with these requirements will result in a \$500 reduction in Benefits for Hospice Services, if, upon receipt of a claim, Benefits are available under this Contract.**

## **DENTAL SERVICES FOR ACCIDENTAL INJURY**

Dental Services for accidental injury to the jaws, sound natural teeth, mouth or face. Injury caused by chewing or biting an object or substance placed in your mouth is not considered an accidental injury, regardless of whether you knew the object or substance was capable of causing such injury if chewed or bitten.

## **DIABETES EQUIPMENT, SUPPLIES AND SELF-MANAGEMENT SERVICES**

- The following equipment, supplies and related services for the treatment of Type I, Type II, and gestational diabetes when Medically Necessary and when recommended or prescribed by a Physician or other Provider:
  - Blood glucose monitors;
  - Blood glucose monitors to the legally blind;
  - Test strips for glucose monitors;
  - Visual reading and urine testing strips;
  - Insulin;
  - Injection aids;
  - Cartridges for the legally blind;
  - Syringes;
  - Insulin pumps and appurtenances thereto;
  - Insulin infusion devices;
  - Oral agents for controlling blood sugar;
  - Podiatric appliances for prevention of complications associated with diabetes; and
  - Other diabetes equipment and related services that are determined Medically Necessary by the Oklahoma State Board of Health, provided such equipment and supplies have been approved by the federal Food and Drug Administration (FDA).
- Diabetes self-management training in an Inpatient or Outpatient setting which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalizations and complications. Diabetes self-management training must be conducted in accordance with the standards developed by the Oklahoma State Board of Health in consultation with a national diabetes association affiliated with this state and at least three medical directors of health benefit plans selected by the Oklahoma State Department of Health. Coverage for diabetes self-management

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training, including medical nutrition therapy relating to diet, caloric intake, and diabetes management (excluding programs the only purpose of which are weight reduction) shall be limited to the following:

- Visits Medically Necessary upon the diagnosis of diabetes;
- A Physician diagnosis which represents a significant change in the patient's symptoms or condition making Medically Necessary changes in the patient's self-management; and
- Visits when reeducation or refresher training is Medically Necessary.

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

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

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

## **SERVICES RELATED TO CLINICAL TRIALS**

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

- Any of the following federally funded or approved trials:
  - The Centers for Disease Control and Prevention of the United States Department of Health and Human Services;
  - The National Institutes of Health (NIH);
  - The Centers for Medicare and Medicaid Services;
  - The Agency for Healthcare Research and Quality;
  - A cooperative group or center of any of the previous entities;
  - The United States Food and Drug Administration;
  - The United States Department of Defense (DOD);
  - The United States Department of Veterans Affairs (VA);
  - A qualified non-governmental research entity identified in guidelines issued by the NIH for center support grants or the DOD, VA or Department of Energy if the study has been reviewed and approved through a peer review system; or
  - An institutional review board of an institution in this state that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services.
- A clinical trial conducted under an FDA investigational new drug application.
- A drug trial that is exempt from the requirement of an FDA investigational new drug application.

Benefits may not be available under this section for services that are paid for by the research institution conducting the clinical trial.

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

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

## **DURABLE MEDICAL EQUIPMENT**

The rental or, at the Plan's option, the purchase of Durable Medical Equipment, provided such equipment meets the following criteria:

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

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

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

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

## **PROSTHETIC APPLIANCES**

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

## **ORTHOTIC DEVICES**

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

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Benefits will be provided for the following orthotic devices:

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

Not covered are:

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

**Benefits for orthotic devices are limited to the maximum amount specified in the *Schedule of Benefits for Comprehensive Health Care Services* in the front of this Contract.**

### **WIGS OR OTHER SCALP PROSTHESES**

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

**Benefits are limited to the maximum amount specified in the *Schedule of Benefits for Comprehensive Health Care Services* in the front of this Contract.**

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## ***Outpatient Prescription Drug Benefits and Related Services***

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

### **COVERED SERVICES**

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

- Prescription Drugs dispensed for a Subscriber's Outpatient use, when recommended by and while under the care of a Physician or other Provider.
- Injectable insulin and insulin products, but only when dispensed in accordance with a written prescription by a licensed Physician or other Provider even though a prescription may not be required by law.
- Oral contraceptives, when prescribed by a licensed Physician or other Provider.
- Prescription Drugs prescribed for treatment of attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD), subject to the Plan's requirements for Preauthorization.
- Oral Chemotherapy when prescribed by a licensed Physician. Coverage of prescribed orally administered anticancer medications will be provided on a basis no less favorable than intravenously administered or injected cancer medications.
- Self-injectable and other self-administered Prescription Drugs (including Chemotherapy), when dispensed by a Pharmacy. Self-administered drugs purchased from a Physician and administered in his/her office are not covered. Many self-injectable/self-administered drugs are classified as "Specialty Pharmacy Drugs" and may be purchased from a Participating Specialty Pharmacy.
- Specialty Pharmacy Drugs (when dispensed by a Pharmacy participating in the Specialty Pharmacy Network).
- Vaccinations (when administered by a participating Retail Pharmacy Vaccination Network Provider). Visit the Plan's Web site at [www.bcbsok.com](http://www.bcbsok.com) for a current listing of vaccines available through this coverage. NOTE: Vaccinations administered through a Participating Retail Pharmacy Vaccination Network Provider are not subject to the Deductible, Copayment and/or Coinsurance provisions of this Contract.

In order to be a Covered Drug under this ***Outpatient Prescription Drug Benefits and Related Services*** section, the Prescription Drugs must be shown on the Drug List. The drugs on the Drug List have been selected to provide coverage for a broad range of diseases. Each drug appearing on the list shows to which tiered category it belongs. For example, Generic Drugs are categorized as Tier 1 drugs, while Specialty Drugs may be classified as Tier 4 or Tier 5 (depending upon the benefit plan in which you are enrolled). You may refer to the ***Schedule of Benefits for Outpatient Prescription Drugs and Related Services*** to determine the level of coverage available for each drug tier/category.

### **RETAIL PHARMACY PROGRAM**

The Benefits you receive and the amount you pay will vary depending upon the type of drugs, or supplies obtained and whether they are obtained from a Participating Pharmacy or Out-of-Network Pharmacy. Your cost will be the appropriate Deductible, Copayment and/or Coinsurance amount indicated in the ***Schedule of Benefits for Outpatient Prescription Drugs and Related Services***.

## **EXTENDED RETAIL PRESCRIPTION DRUG SUPPLY PROGRAM**

Your coverage includes Benefits for a 90-day supply of Maintenance Prescription Drugs purchased from a Participating Prescription Drug Provider which may only include retail or home delivery pharmacies. Benefit amounts are listed in the *Schedule of Benefits for Outpatient Prescription Drugs and Related Services*. Your cost will be the appropriate Deductible, Copayment and/or Coinsurance amount indicated in the *Schedule of Benefits for Outpatient Prescription Drugs and Related Services*.

Benefits will not be provided for a 90-day supply of drugs obtained from a Prescription Drug Provider not participating in the Extended Retail Prescription Drug Supply Program.

## **MAIL-ORDER PHARMACY PROGRAM**

The Plan has selected a Mail-Order Pharmacy Program to fill and deliver maintenance (long-term) medications. ***You are encouraged to fill these Maintenance Prescription Drugs through the Mail-Order Pharmacy.***

The Mail-Order Pharmacy Program provides delivery of Maintenance Prescription Drugs directly to your home address. All items that are covered under the Mail-Order Pharmacy Program are the same items that are covered under the Retail Pharmacy Program and are subject to the same limitations and exclusions. **Items covered through a Specialty Pharmacy may not be covered through the Mail-Order Pharmacy Program.** NOTE: Prescription Drugs and other items may not be mailed outside the United States.

Some drugs may not be available through the Mail-Order Pharmacy Program. If you have any questions about this Mail-Order Pharmacy Program, need assistance in determining the amount of your payment, or need to obtain the mail-order prescription form, you may access the Web site at [www.bcbsok.com](http://www.bcbsok.com) or contact Customer Service at the toll-free number on your Identification Card. Mail the completed form, your Prescription Order(s) and payment to the address indicated on the form.

Your cost will be the appropriate Deductible, Copayment and/or Coinsurance amount indicated in the *Schedule of Benefits for Outpatient Prescription Drugs and Related Services*.

If you send an incorrect payment amount for the Prescription Order dispensed, you will: (a) receive a credit if the payment is too much; or (b) be billed for the appropriate amount if it is not enough.

## **SPECIALTY PHARMACY PROGRAM**

The Specialty Pharmacy Drug delivery service integrates Specialty Pharmacy Drug Benefits with your overall medical and Prescription Drug Benefits. This program provides delivery of medications directly to your health care Provider for administration or to the home of the patient that is undergoing treatment for a complex medical condition. **Due to special storage requirements and high cost, Specialty Drugs are not covered unless obtained through the Specialty Pharmacy Drug Program, unless coverage is specifically provided elsewhere in this Contract and/or is required by applicable law or regulation.**

The Specialty Pharmacy Drug Program delivery service offers:

- Coordination of coverage among you, your health care Provider and the Plan;
- Educational materials about the patient's particular condition and information about managing potential medication side effects;
- Syringes, sharps containers, alcohol swabs and other supplies with every shipment for FDA approved self-injectable/self-administered medications; and
- Access to a pharmacist for urgent medication issues 24 hours a day, seven days a week, 365 days each year.

A list identifying these Specialty Pharmacy Drugs is available by accessing the Web site at [www.bcbsok.com](http://www.bcbsok.com) or by contacting Customer Service at the toll-free number on your Identification Card. Your cost will be the appropriate Deductible, Copayment and/or Coinsurance amount indicated in the *Schedule of Benefits for Outpatient Prescription Drugs and Related Services*.



## PAYMENT OF BENEFITS

- Benefits are provided for Prescription Drugs dispensed for a Subscriber's Outpatient use when recommended by and while under the care of a Physician or other Provider, provided such care and treatment is Medically Necessary.
- Benefits for Prescription drugs are available to the Subscriber only:
  - in accordance with a Prescription Order; and
  - after the Subscriber has met the Deductible, if applicable; and
  - after the Subscriber has incurred charges equal to the Copayment and/or Coinsurance applicable to each Prescription Order. **If the charge for your prescription is less than your Copayment and/or Coinsurance, you will pay the lesser amount.**
- When Prescription Drugs and related services are dispensed by a Participating Pharmacy, the Plan will pay directly to the Pharmacy the Allowable Charge for the drugs, less the applicable Deductible, Copayment and/or Coinsurance amount specified in the *Schedule of Benefits for Outpatient Prescription Drugs and Related Services*.
- If your Prescription Order is filled by an Out-of-Network Pharmacy, you will need to pay the full cost of the drugs directly to the Pharmacy and then submit a claim to the Plan in order to receive any Benefits under this program. In addition to any Deductible, Copayment and/or Coinsurance amounts applicable to your coverage, you will be responsible for the cost difference, if any, between the Pharmacy's billed charges and the Allowable Charge determined by the Plan. **NOTE: Vaccinations administered by a Pharmacy that is not a Participating Retail Pharmacy Vaccination Network Provider are not covered under this Outpatient Prescription Drugs and Related Services section.**

## PRESCRIPTION DRUG SUPPLY/DISPENSING LIMITS

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

### • Benefit Supply Limits per Prescription

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

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

- **Retail Pharmacy and Specialty Pharmacy Network Providers** – During each one-month period, up to a 30-day supply for “non-maintenance” and Specialty Pharmacy Drugs.
- **Extended Retail Prescription Drug Supply Program and Mail-Order Pharmacy Program** – During each three-month period, up to a 90-day supply for drugs designated by the Plan as Maintenance Prescription Drugs. If less than a 90-day supply is ordered, the extended retail supply/mail-order Copayment and/or Coinsurance will still apply.

A separate Copayment and/or Coinsurance amount will apply to each fill of a medication having a unique strength, dosage or dosage form.

A separate Copayment and/or Coinsurance amount will apply to each fill of a prescription purchased on the same day for insulin and insulin syringes.

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

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

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

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

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

- **Controlled Substances Limitation**

If the Plan determines that a Subscriber may be receiving quantities of controlled substance medications not supported by FDA approved dosages or recognized treatment guidelines, any Benefits for additional drugs may be subject to a review for Medical Necessity, appropriateness and other restrictions.

## **EXCLUSIONS AND LIMITATIONS**

In addition to the exclusions and limitations specified in the **Exclusions** section of this Contract, no Benefits will be provided under this **Outpatient Prescription Drugs and Related Services** section for:

- Drugs which are not included on the Drug List, unless specifically covered elsewhere in this Contract and/or such coverage is required in accordance with applicable law or regulation.
- Drugs which by law do not require a Prescription Order from an authorized Provider (except insulin, insulin analogs, insulin pens, and prescriptive and nonprescriptive oral agents for controlling blood sugar level); and drugs, insulin or covered devices for which no valid Prescription Order is obtained.
- Over-the-counter drugs and medications, except those prescribed by a Physician or other Provider as part of the "Preventive Care Services" as defined in this Contract.
- Devices or Durable Medical Equipment of any type (even though such devices may require a Prescription Order), such as, but not limited to, therapeutic devices, artificial appliances, or similar devices (**except** disposable hypodermic needles and syringes for self-administered injections).
- Administration or injection of any drugs (except for vaccines administered by a Participating Pharmacy).
- Vitamins (**except** those vitamins which by law require a Prescription Order and for which there is **no** non-prescription alternative).
- Drugs dispensed in a Physician's office or during confinement while a patient in a Hospital, or other acute care institution or facility, including take-home drugs; and drugs dispensed by a nursing home or custodial or chronic care institution or facility.
- Covered Drugs, devices, or other Pharmacy services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States (including but not limited to, any services or supplies for which benefits are

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payable under Part A and Part B of Title XVIII of the Social Security Act (Medicare), or the laws, regulations or established procedures of any county or municipality, except any program which is a state plan for medical assistance (Medicaid), or any Prescription Drug which may be properly obtained without charge under local, state, or federal programs, unless such exclusion is expressly prohibited by law; provided, however, that this exclusion shall not be applicable to any coverage held by the Member for Prescription Drug expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.

- Any services provided or items furnished for which the Pharmacy normally does not charge.
- Covered Drugs for which the Pharmacy's usual and customary charge to the general public is less than or equal to the Copayment and/or Coinsurance amount provided under this Contract.
- Infertility and fertility medications.
- Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.
- Drugs required by law to be labeled: "Caution — Limited by Federal Law to Investigational Use," or Experimental drugs, even though a claim is made for the drugs.
- Covered Drugs dispensed in quantities in excess of the amounts stipulated in this ***Outpatient Prescription Drugs and Related Services*** section; or refills of any prescriptions in excess of the number of refills specified by the Physician or by law; or any drugs or medicines dispensed more than one year following the Prescription Order date.
- Drugs which are not approved by the U.S. Food and Drug Administration (FDA) for a particular use or purpose or when used for a purpose other than the purpose for which the FDA approval is given, except as required by law or regulation. This exclusion is not applicable to the coverage of the off-label use of Prescription Drugs for the treatment of cancer or the study of oncology in accordance with Oklahoma law.
- Fluids, solutions, nutrients, medications (including all additives and Chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous, intramuscular (in the muscle), intrathecal (in the spine), or intraarticular (in the joint) injection in the home setting, except as specifically provided in this Contract. NOTE: This exception does not apply to dietary formula necessary for the treatment of phenylketonuria (PKU) or other heritable diseases.
- Drugs prescribed and dispensed for the treatment of obesity or for use in any program of weight reduction, weight loss, or dietary control.
- Drugs the use or intended use of which would be illegal, unethical, imprudent, abusive, not Medically Necessary, or otherwise improper.
- Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the Identification Card.
- Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction which is not covered under this Contract, or for which Benefits have been exhausted.
- Rogaine, Minoxidil or any other drugs, medications, solutions or preparations used or intended for use in the treatment of hair loss, hair thinning or any related condition, whether to facilitate or promote hair growth, to replace lost hair, or otherwise.
- Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.
- Prescription Orders for which there is an over-the-counter product available with the same active ingredient(s), in the same strength, unless otherwise determined by the Plan.
- Athletic performance enhancement drugs.
- Drugs to treat sexual dysfunction or erectile dysfunction, including, but not limited to, sildenafil citrate (Viagra), phentolamine (Regitine), alprostadil (Prostin, Edex, Caverject), and apomorphine.

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- Compounded medications. For purposes of this exclusion, “compounded medications” are substances made by mixing, reconstituting or other such acts, not in accordance with directions contained in Food and Drug Administration (FDA) approved labeling provided by the product's manufacturer and other FDA-approved manufacturer directions consistent with that labeling.
- Replacement of drugs or other items that have been lost, stolen, destroyed, or misplaced.
- Shipping, handling, or delivery charges.
- Prescription Drugs required for international travel or work.
- Certain drug classes where there are over-the counter alternatives available.
- Drugs which are repackaged by anyone other than the original manufacturer.

## **BRAND NAME DRUG EXCLUSION**

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

## **PRESCRIPTION DRUG PREAUTHORIZATION PROCESS**

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

A form of Preauthorization is our Step Therapy program – a “step” approach to providing Benefits for certain medications your Physician or other Provider prescribes for you. This means that you may first need to try one or more “prerequisite” medications before certain high-cost medications are approved for coverage under your Prescription Drug program. Although you may currently be on therapy, your claim may need to be reviewed to see if the criteria for coverage of further treatment has been met. A documented treatment with a Generic Drug or brand name therapeutic alternative medication may be required for continued coverage of the Brand Name Drug.

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

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

You can obtain a listing of the drugs which require Preauthorization by contacting a Customer Service Representative at the number on the back your Identification Card. Or, you may request a listing by writing to:

Blue Cross and Blue Shield of Oklahoma  
P.O. Box 3235  
Naperville, IL 60566–7235

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

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

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

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

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

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

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

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

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

- If Preauthorization is approved for the drug, you may return to the Pharmacy to obtain the full Prescription Order, subject to any Deductible, Copayment and/or Coinsurance amount applicable to the balance of the drug quantity dispensed.
- If the Preauthorization is denied, you may obtain your Prescription Order by paying the full cost for the drugs.
- Regardless of the Plan's decision, you will be notified in writing regarding the outcome of your Preauthorization approval request.

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

Blue Cross and Blue Shield of Oklahoma  
P.O. Box 3235  
Naperville, IL 60566-7235

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

**To view a listing of the drugs which are included in the Preauthorization/Step Therapy program, please visit our Web site at [www.bcbsok.com](http://www.bcbsok.com). If you have questions about Step Therapy, or any other aspects of the Preauthorization process, please call a Customer Service Representative at the number shown on your Identification Card for assistance.**

## **EXCEPTION REQUESTS**

If your prescribed drug is not on the Drug List, you, your authorized representative, or your Provider can request an exception by contacting us at the telephone number shown on your Identification Card. Along with your request, your Provider should submit a supporting statement explaining why the drug is needed to treat your condition. The Plan will provide notice of our decision no later than 72 hours after receipt of your Provider's supporting statement. If approved, the drug will be covered at a cost-sharing level pre-determined by the Plan.

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If you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function, or if you are undergoing a current course of treatment using a drug that is not on the Drug List, expedited review may be requested. The supporting statement from your Provider should indicate that an exigency exists, discuss the harm that could result if the requested drug is not provided on an expedited basis, and explain why the drug is needed to treat your condition. The Plan will provide notice of our decision no later than 24 hours after receipt of the supporting statement from your Provider. If your exception request is approved, the drug will be covered for the duration of the exigency at a cost-sharing level pre-determined by the Plan.

If your exception request is denied, you may appeal the decision as described in the *Complaint/Appeal Procedure* section of this Contract. You will also receive information about the appeals process with the denial letter.

Sample

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## *Exclusions*

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

### **WHAT IS NOT COVERED**

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

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

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- For cosmetic Surgery or complications resulting therefrom, including Surgery to improve or restore your appearance, unless:
  - needed to repair conditions resulting from an accidental injury; or
  - for the improvement of the physiological functioning of a malformed body member resulting from a congenital defect.

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

- Received from a member of your immediate family.
- Received before your Effective Date.
- Received after your coverage stops.
- For any Inpatient care and services, including rehabilitation care and services, unless documentation can be provided that, due to the nature of the services rendered or your condition, you cannot receive safe or adequate care as an Outpatient.
- For personal hygiene and convenience items regardless of whether or not recommended by a Physician or other Provider. Examples include: computers; air conditioners, air purifiers or filters; humidifiers; or physical fitness equipment, including exercise bicycles or treadmills; or modifications to your home or vehicle.
- For telephone consultations, email or other electronic consultations (except electronic consultations occurring with a Provider in connection with a “medical home” program that has been approved by the Plan), missed appointments, or completion of a claim form.
- For Custodial Care such as sitters' or homemakers' services, or care in a place that serves you primarily as a residence when you do not require skilled nursing.
- For foot care only to improve comfort or appearance such as care for flat feet, subluxation, corns, bunions (except capsular and bone Surgery), calluses, toenails, and the like.
- For routine, screening or periodic physical examinations which are not included as “Preventive Care Services,” as specified in the *Comprehensive Health Care Services* section of this Contract.
- For reverse sterilization.
- For female contraceptive devices when not prescribed by a licensed Provider, including over-the-counter contraceptive products. Contraceptive medications or devices for male use are excluded.
- For Orthognathic Surgery, osteotomy, or any other form of oral Surgery, dentistry, or dental processes to the teeth and surrounding tissue (including complications resulting therefrom), except for:
  - the treatment of accidental injury to the jaw, sound natural teeth, mouth or face; or
  - for the improvement of the physiological functioning of a malformed body member resulting from a congenital defect.

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

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

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- severely disabled; or
- eight years of age or under and who has a medical or emotional condition which requires hospitalization or general anesthesia for dental care; or
- four years of age or under, who in the judgment of the practitioner treating the child, is not of sufficient emotional development to undergo a Medically Necessary dental procedure without the use of anesthesia.
- For eyeglasses, contact lenses or examinations for prescribing or fitting them, except for:
  - aphakic patients (including lenses required after cataract Surgery) and soft lenses or sclera shells to treat disease or injury;
  - vision examinations performed in connection with the diagnosis or treatment of disease or injury; or
  - services specified under “Preventive Care Services” or in the “Pediatric Vision Care Addendum” attached to this Contract.
- For eye Surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).
- For hearing aids, tinnitus maskers, or examinations for prescribing or fitting them, except as specified for Subscribers under age 18. Hearing examinations not related to the prescription or fitting of hearing aids will be a Covered Service only when performed in connection with the diagnosis or treatment of disease or injury, or as specified under “Preventive Care Services”.
- For transsexual Surgery or any treatment leading to or in connection with transsexual Surgery.
- 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 your reproductive ability.
- For treatment of sexual problems not caused by organic disease
- For treatment of obesity, including morbid obesity, regardless of the patient's history or diagnosis, including but not limited to the following: weight reduction or dietary control programs; surgical procedures; prescription or nonprescription drugs or medications such as vitamins (whether to be taken orally or by injection), minerals, appetite suppressants, or nutritional supplements; and any complications resulting from weight loss treatments or procedures.
- For smoking cessation programs, not including counseling as specified under “Preventive Care Services”.
- For medication, drugs or hormones to stimulate growth.
- For or related to acupuncture, whether for medical or anesthesia purposes.
- For conditions related to hyperkinetic syndromes, learning disabilities, mental retardation, or for Inpatient confinement for environmental change. This exclusion **shall not** apply to the following Medically Necessary services:
  - Physician’s Services or other Provider (except for neuropsychological testing) related to the diagnosis and treatment of attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD); or
  - Prescription Drug therapy for treatment of ADD/ADHD.
- For unspecified developmental disorders or autistic disease of childhood, except as specified in the **Comprehensive Health Care Services** section under “Services Related to Treatment of Autism and Autism Spectrum Disorders.”
- For or related to applied behavior analysis.

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- For hippotherapy, equine assisted learning, or other therapeutic riding programs.
- For which the Provider of service customarily makes no direct charge to a Subscriber.
- For treatment of temporomandibular joint dysfunction, including but not limited to diagnostic procedures, splints, orthodontic/orthopedic appliances, restorations necessary to increase vertical dimension or to restore or maintain functional or centric occlusion, alteration of teeth or jaws, Physical Therapy, and medication and behavioral modification related to conditions of temporomandibular joint syndrome or any other conditions involving the jaw joint, adjacent muscles or nerves, regardless of cause or diagnosis.
- For or related to transplantation of donor organs, tissues or bone marrow, except as specified under “Human Organ, Tissue and Bone Marrow Transplant Services.”
- For Physician standby services.
- For Continuous Passive Motion (CPM) devices used in treatment of the shoulder or other joints, except for up to 21 days postoperatively for the following surgical procedures: total knee arthroplasty, anterior cruciate ligament reconstruction, or open reduction and internal fixation of tibial plateau for distal femur fractures involving the knee joint.
- For ductal lavage of the mammary ducts.
- For extracorporeal shock wave treatment, also known as orthotripsy, using either a high-or low-dose protocol, for treatment of plantar fasciitis and all other musculoskeletal conditions.
- For orthoptic training.
- For thermal capsulorrhaphy as a treatment of joint instability, including but not limited to instability of shoulders, knees and elbows.
- For elective abortion, unless the life of the mother is endangered.
- For transcutaneous electrical nerve stimulator (TENS).
- For Inpatient drug and alcohol treatment that is not rendered in a Hospital, Psychiatric Hospital, Residential Treatment Center or other Plan-approved Provider.
- For massage therapy, including but not limited to effleurage, petrissage and/or tapotement.
- Which are not specifically named as Covered Services subject to any other specific Exclusions and limitations in this Contract.

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

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## *General Provisions*

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This section tells:

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

### **ENTIRE CONTRACT; CHANGES**

This Contract, with the application and the Identification Card, is the entire Contract between you and the Plan. No change in this Contract will be effective until approved by an authorized Plan officer. This approval must be noted on nor 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 Subscriber or by an individual Member 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.

### **BENEFITS TO WHICH YOU ARE ENTITLED**

We provide only the Benefits specified in this Contract.

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

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

### **PRIOR APPROVAL**

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

### **NOTICE AND PROPERLY FILED CLAIM**

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

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

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

## **PREMIUMS AND CONTRACT CHANGES**

The amount of premium shall be the amount determined by the Plan for the Benefits of this Contract.

The Plan is hereby granted discretionary authority to determine, alter and interpret the provisions, language and Benefits set forth in this Contract or the payment of premiums therefor. Any material modifications and/or amendments to your coverage that affect the content of the Summary of Benefits and Coverage (SBC), other than changes coinciding with the Policy Year renewal date, will be made only upon 60 days' notice to the Member prior to the date on which the modification or amendment will become effective. The Plan may change premiums upon 31 days' notice to the Member prior to the Policy Year renewal, or as permitted by applicable law.

All premiums for coverage shall be paid to the Plan and shall be payable on or before each Member'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 Member billing notice.

A Tobacco User may be subject to a premium variance of up to 1.5 times the rate applicable to those who are not Tobacco Users, to the extent permitted by applicable law, provided that the Plan will provide an opportunity to offset such premium variation through participation in a wellness program.

The Affordable Care Act (ACA) requires that covered entities providing health insurance ("health insurer") pay an annual fee to the federal government (the "Health Insurer Fee"). The amount of this fee for a Calendar Year will be determined by the federal government and involves a formula based in part on a health insurer's net premiums from the preceding Calendar Year. In addition, ACA provides for the establishment of temporary transitional reinsurance program(s) that will run through 2016 and will be funded by reinsurance contributions ("Reinsurance Fee") from health insurance issuers and self-funded group health plans. Federal and state governments will provide information as to how the reinsurance fee is calculated. Your premium has been adjusted to reflect the effects of the Health Insurer Fees and the Reinsurance Fees.

## **GRACE PERIOD**

A grace period of 31 days will be granted for the payment of each premium falling due after the first premium, during which grace period, the Contract shall continue in force. After a grace period of 31 days, coverage under this Contract will automatically terminate on the last day of the coverage period for which premiums have been paid.

## **PREMIUM REBATES, PREMIUM ABATEMENTS AND COST-SHARING**

- **Rebate.** In the event federal or state law requires the Plan to rebate a portion of annual premiums paid, the Plan will directly provide any rebate owed Members or former Members to such persons in amounts as required by law.
- **Abatement.** The Plan may from time to time determine to abate (in whole or in part) the premium due under this Contract for particular period(s).
- Any abatement of premium by the Plan represents a determination by the Plan not to collect premium for the applicable period(s) and does not effect a reduction in the rates under this Contract. An abatement for one period shall not constitute a precedent or create an expectation or right as to any abatement in any future period(s).
  - The Plan makes no representation or warranty that any rebate or abatement owed or provided is exempt from any federal, state, or local taxes (including any related notice, withholding or reporting requirements). It will be the obligation of each Member or former Member (if applicable) owed or provided a rebate or an abatement to determine the applicability of and comply with any applicable federal, state or local laws or regulations.

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- Cost-Sharing. The Plan reserves the right from time to time to waive or reduce any Coinsurance amount, Copayment amounts and/or Deductibles under this Contract.

## **TIME LIMIT ON CERTAIN DEFENSES**

After two years from the Effective Date of coverage for any Subscriber, no misstatements or omissions, except fraudulent misstatements or omissions, made in the application for coverage shall be used to void this Contract or to deny a claim for loss incurred after the expiration of such two-year period.

No claim for loss incurred after two years from the Effective Date of this Contract shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the Subscriber's Effective Date. However, this provision shall not apply to a disease or physical condition for which a fraudulent misstatement or omission was made by the Subscriber in his/her application for coverage.

## **LIMITATION OF ACTIONS**

No legal action may be taken to recover Benefits within 60 days after a Properly Filed Claim has been made. No such action may be taken later than three years after expiration of the time within which a Properly Filed Claim is required by this Contract. In addition, the Subscriber must exhaust his/her appeal rights, as set forth in the "**Complaint/Appeal Procedure**" section of this Contract, before pursuing other legal remedies.

## **PAYMENT OF BENEFITS**

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

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

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

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

## **OUT-OF-AREA SERVICES**

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

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

- **BlueCard® Program**

Under the BlueCard® Program, when you access Covered Services within the geographic area served by a Host Blue, we will remain responsible for fulfilling our contractual obligations. However, the Host Blue is

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responsible for contracting with and generally handling all interactions with its participating health care Providers.

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

- The billed charges for your Covered Services; or
- The negotiated price that the Host Blue makes available to us.

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

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

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

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

- **Subscriber Liability Calculation**

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

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

- **Exceptions**

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

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

## **MEMBER DATA SHARING**

You may, under certain circumstances, as specified below, apply for and obtain, subject to any applicable terms and conditions, replacement coverage. The replacement coverage will be that which is offered by Blue Cross and Blue Shield of Oklahoma, a division of Health Care Service Corporation, or, if you do not reside in the Blue

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

## **DETERMINATION OF BENEFITS AND UTILIZATION REVIEW**

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

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

The Plan's medical staff may conduct a medical review of your 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 your discharge diagnosis.

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

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

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

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

## **SUBSCRIBER/PROVIDER RELATIONSHIP**

The choice of a Provider is solely yours.

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

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

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

## ACTUARIAL VALUE

The use of a metallic name in your *Schedule of Benefits* or Outline of Coverage, such as Platinum, Gold, Silver or Bronze, or other statements with respect to a health benefit plan's actuarial value, is not an indicator of the actual amount of expenses that a particular person will be responsible to pay out of his/her own pocket. A person's out of pocket expenses will vary depending on many factors, such as the particular health care services, health care providers and particular benefit plan chosen. Please note that metallic names reflect only an approximation of the actuarial value of a particular benefit plan.

## PHYSICAL EXAMINATION/AUTOPSY

The Plan, at its own expense, shall have the right and opportunity to examine the Subscriber when and as often as it may reasonably require during the pendency of a claim hereunder and to request an autopsy in case of death where it is not forbidden by law.

## COORDINATION OF BENEFITS

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

- **Definitions**

In addition to the *Definitions* of this Contract, the following definitions apply to this provision.

“*Other Contract*” means any arrangement, providing health care benefits or services through:

- Group, group-type, non-group, individual, blanket or franchise insurance coverage;
- Blue Cross Plan, Blue Shield Plan, health maintenance organization and other prepayment coverage;
- Coverage under labor-management trustee plans, union welfare plans, employer organization plans or employee benefit organization plans;
- Coverage toward the cost of which any employer has contributed, or with respect to which any employer has made payroll deduction;
- Group or individual automobile insurance coverage; and
- Coverage under any tax supported or government program, including Medicare, to the extent permitted by law.

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

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

“*Dependent*” additionally means a person who qualifies as a Dependent under an Other Contract.

- **Effect On Benefits**

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

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



**When we are secondary, the Benefits we provide for Covered Services may be reduced because of benefits received from the Other Contracts.**

- **Order of Benefit Determination**

- When a person who received care is covered as an employee under one group contract, and as a Dependent under another, then the employee coverage pays first.
- When a Dependent child is covered under two group contracts, the contract covering the child as a Dependent of the parent whose birthday falls earliest in the Calendar Year pays first. (If one contract does not follow the “birthday rule” provision, then the rule followed by that contract is used to determine the order of benefits.)

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

- If the parent with custody of the child has not remarried, the coverage of the parent with custody pays first.
- When a divorced parent with custody has remarried, the coverage of the parent with custody pays first and the stepparent’s coverage pays second before the coverage of the parent who does not have custody.
- Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child’s health care expenses, the coverage of that parent pays first.
- When none of the above circumstances applies, the coverage you have had for the longest time pays first, except that a contract which covers you as a laid-off or retired employee or as a Dependent of such person pays after a contract which covers you as other than a laid-off or retired employee or Dependent of such person.
- When the Plan requests information from another carrier to determine the extent or order of your benefits under an Other Contract, and such information is not furnished after a reasonable time, then the Plan shall:
  - Assume the Other Contract is required to determine its benefits first;
  - Assume the benefits of the Other Contract are identical to the Benefits of this coverage and pay its Benefits accordingly.

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

- If the other carrier reduces your benefits because of payment you received under this coverage and the above rules do not allow such reduction, then the Plan will advance the remainder of its full Benefits under this coverage as if your Benefits had been determined in absence of an Other Contract. **However, the Plan shall be subrogated to all of your rights under the Other Contract.** You must furnish all information reasonably required by the Plan in such event, and you must cooperate and assist the Plan in recovery of such sums from the other carrier:
- If the other carrier later provides benefits to you for which the Plan has made payments or advances under this Coordination of Benefits provision, you must hold all such payments in trust for the Plan and must pay such amount to the Plan upon receipt.

- **Facility of Payment**

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

- **Right of Recovery**

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

## **PLAN'S RIGHT OF RECOUPMENT**

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

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

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

## **LIMITATIONS ON PLAN'S RIGHT OF RECOUPMENT/RECOVERY**

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

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

## **PLAN/ASSOCIATION RELATIONSHIP**

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

## **THE PLAN'S SEPARATE FINANCIAL ARRANGEMENTS WITH PRESCRIPTION DRUG PROVIDERS**

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

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

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

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

## **THE PLAN'S SEPARATE FINANCIAL ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS**

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

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

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## **NOTICE OF ANNUAL MEETING**

You are hereby notified that you are a Member of Blue Cross and Blue Shield of Oklahoma, a division of Health Care Service Corporation, a Mutual Legal Reserve Company (“HCSC”), and you are entitled to vote in person, or by proxy, at all meetings of HCSC. The annual meeting is held at our principal office at 300 East Randolph, Chicago, Illinois each year on the last Tuesday in October at 12:30 p.m.

The term “Member” as used above refers only to the person to whom this Contract is issued. It does not include any other family members covered under family coverage unless such family member is acting on your behalf.

Sample

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## *Subscriber Rights*

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

**You have the right to:**

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

Sample

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## *Claims Filing Procedures*

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

### **PARTICIPATING PROVIDERS**

Participating Providers, even those outside your network, have agreed to submit claims directly to the Plan for you. Simply show your Identification Card, and claims submission will be handled for you. If you use an Out-of-Network Provider who does not file for you, you should follow the guidelines below in submitting your claims.

#### **REMEMBER...**

**To receive the maximum Benefits under this Contract for your Covered Services, you must receive treatment from Network Providers.**

### **PRESCRIPTION DRUG CLAIMS**

**To be eligible for maximum Benefits and automatic claims filing, always use Participating Pharmacies.**

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

### **HOSPITAL CLAIMS**

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

### **AMBULATORY SURGICAL FACILITY AND OTHER FACILITY CLAIMS**

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

### **PHYSICIAN AND OTHER PROVIDER CLAIMS**

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

## **MEMBER-FILED CLAIMS**

When you must file a claim yourself, you may obtain claim forms by contacting the Plan. Be sure to fill out the claim form completely, sign it, and attach the Provider's itemized statement. Send the completed form to:

Blue Cross and Blue Shield of Oklahoma  
P.O. Box 3235  
Naperville, IL 60566 – 7235

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

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

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

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

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

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

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

## **BENEFIT DETERMINATIONS FOR PROPERLY FILED CLAIMS**

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

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

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

The procedure for appealing an Adverse Benefit Determination is set forth in the section entitled, ***“Complaint/Appeal Procedure.”***

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## **DIRECT CLAIMS LINE**

You may call a Customer Service Representative at the number shown on your Identification Card between 8:00 a.m. and 6:00 p.m., Monday through Friday, whenever you have a question concerning a claim or your membership.

Sample

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## *Complaint/Appeal Procedure*

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

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

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

### **CLAIM DETERMINATIONS**

When the Plan receives a Properly Filed Claim, it has authority and discretion under this Contract to interpret and determine Benefits in accordance with the Contract provisions.

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

### **IF A CLAIM IS DENIED OR NOT PAID IN FULL**

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

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

- The reasons for the determination;
- A reference to the Benefit provisions on which the determination is based, or the contractual, administrative or protocol for the determination;
- A description of additional information which may be necessary to perfect the claim and an explanation of why such material is necessary;
- Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care Provider, claim amount (if applicable), and a statement describing denial with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
- An explanation of our internal review/appeals and external review processes (and how to initiate a review/appeal or external review);
- In certain situations, a statement in non-English language(s) that the written notice of the claim denial and certain other benefit information may be available (upon request) in such non-English language(s);
- In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by us;

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- The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for Benefits;
- Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
- An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances, if the denial was based on medical necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;
- In the case of a denial of an Urgent Care Claim, a description of the expedited review procedure applicable to such claims. An Urgent Care Claim decision may be provided orally, so long as a written notice is furnished to the claimant within three days of oral notification; and
- Contact information for applicable office of health insurance consumer assistance or ombudsman.

#### **TIMING OF REQUIRED NOTICES AND EXTENSIONS**

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

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

#### **URGENT CARE CLAIMS\***

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

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

#### **PRE-SERVICE CLAIMS**

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

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

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POST-SERVICE CLAIMS

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

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

CLAIM APPEAL PROCEDURES

- Claim Appeal Procedures – Definitions**

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

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

- Urgent Care/Expedited Clinical Appeals**

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

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

no later than 72 hours after it receives the initial request, or within 48 hours after it receives the missing information (if the initial request is incomplete).

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

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

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

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

- Within 180 days after you receive notice of an Adverse Benefit Determination, you may call or write to our Administrative Office. We will need to know the reasons why you do not agree with the Adverse Benefit Determination. Send your request to:

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

- We will honor telephone requests for information. However, such inquiries will not constitute a request for review.
- In support of your claim review, you have the option of presenting evidence and testimony to us. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of an Adverse Benefit Determination or at any time during the claim review process.

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

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

- ***Timing of Appeal Determinations***

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

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

- ***Notice of Appeal Determination***

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

The written notice to you or your authorized representative will include:

- A reason for the determination;
- A reference to the Benefit provisions on which the determination is based, and the contractual, administrative or protocol for the determination;
- Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care Provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
- An explanation of our external review processes (and how to initiate an external review);
- In certain situations, a statement in non-English language(s) that the written notice of the claim denial and certain other Benefit information may be available (upon request) in such non-English language(s);
- In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by us;
- The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for Benefits;
- Any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
- An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;
- A description of the standard that was used in denying the claim and a discussion of the decision; and
- Contact information for applicable office of health insurance consumer assistance or ombudsman.

#### **EXTERNAL REVIEW RIGHTS**

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

Oklahoma Insurance Department  
P.O. Box 53408  
Oklahoma City, OK 73152-3408  
1-800-522-0071 (Oklahoma only)  
405-521-2991

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

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

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

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

Sample

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## Definitions

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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.

### ADVANCE PREMIUM TAX CREDIT

The advance payment of a refundable premium tax credit an eligible individual may receive for taxable years ending after December 31, 2013, as provided for under applicable law where the advanced payment is used to offset all or a portion of the premium for coverage obtained by that individual through the Exchange.

### ALLOWABLE CHARGE

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

- **For Comprehensive Health Care Services:**
  - **Network 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 Network Provider agreement.
  - **Out-of-Network (Non-Contracting) Providers** – the lesser of: (a) the Provider's billed charge; or (b) the Plan's Non-Contracting Allowable Charge as set forth in the "**Important Information**" section.
- **For Outpatient Prescription Drug Benefits:**
  - **Participating Pharmacies** – the Pharmacy's usual charge, not to exceed the amount the Pharmacy has agreed to accept as payment for Covered Services in accordance with a Participating Pharmacy agreement.
  - **Out-of-Network Pharmacies** – the Pharmacy's usual charge, up to the amount that the Plan would reimburse a Participating Pharmacy for the same service.

**NOTE: For Covered Services received outside the state of Oklahoma, the "Allowable Charge" may be determined by the Blue Cross and Blue Shield Plan (Host Plan) servicing the area. In such case, Benefits will be based upon the Provider payment arrangements in effect between the Provider and the on-site Plan. For information regarding Out-of-Network Provider services refer to "Out-of-Area Services" in the *General Provisions* section for additional information.**

### AMBULATORY SURGICAL FACILITY

A Provider with an organized staff of Physicians which:

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

### BENEFIT PERIOD

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



## **BENEFITS**

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

## **BLUECARD PROVIDER**

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

## **CALENDAR YEAR**

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

## **COINSURANCE**

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

## **CONTRACT**

This agreement including your application and any amendment between you and us.

## **COPAYMENT**

A fixed dollar amount required to be paid by or on behalf of a Subscriber in connection with the delivery of some Covered Services. Refer to the *Schedule of Benefits for Comprehensive Health Care Services* for any Copayments applicable to your coverage.

## **COVERED DRUG**

Any Prescription Drug or injectable drug, including insulin, disposable syringes and needles needed for self-administration:

- Which is included on the applicable Drug List;
- Which is Medically Necessary and is ordered by a Provider naming a Subscriber as the recipient;
- For which a written or verbal Prescription Order is prepared by a Provider;
- For which a separate charge is customarily made;
- Which is not entirely consumed at the time and place that the Prescription Order is written;
- For which the Food and Drug Administration (FDA) has given approval for at least one indication; and
- Which is dispensed by a Pharmacy and is received by the Subscriber while covered under this Contract, *except* when received from a Provider's office, or during confinement while a patient is in a Hospital or other acute care institution or facility.

As new drugs are approved by the Food and Drug Administration (FDA), such drugs, unless intended use is specifically excluded under the Contract, may be eligible for Benefits and will be added to the applicable Drug List. Benefits are available for Covered Drugs as outlined in the *Schedule of Benefits for Outpatient Prescription Drugs and Related Services*.

## **COVERED SERVICE**

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

## **CUSTODIAL CARE**

Aid to patients who need help with daily tasks like bathing, eating, dressing and walking. Custodial Care does not directly treat an injury or illness, and does not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed.

## **DEDUCTIBLE**

A specified amount of Covered Services that you must incur before Benefits are available. Refer to the *Schedule of Benefits for Comprehensive Health Care Services* for any Deductibles applicable to your coverage.

## **DEPENDENT**

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

## **DIAGNOSTIC SERVICE**

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

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

## **DOMESTIC PARTNER**

A companion of the same sex or opposite sex with whom the Member has entered into a Domestic Partnership.

## **DOMESTIC PARTNERSHIP**

A same-sex or opposite sex couple in a committed relationship, similar to a marriage, but without an official marriage license.

## **DURABLE MEDICAL EQUIPMENT**

Equipment which meets the following criteria:

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

## **DRUG LIST**

A list of all drugs that may be provided under the Outpatient Prescription Drug Benefits section of this Contract. The Drug List is available on our Web site at [www.bcbsok.com](http://www.bcbsok.com). You may also contact a Customer Service Representative at the telephone number shown on the back of your Identification Card for more information.

## **EFFECTIVE DATE**

The date when your coverage begins.

## **ELIGIBLE PERSON**

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

## **EMERGENCY CARE**

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

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

## **EXCHANGE (ALSO KNOWN AS "HEALTH INSURANCE MARKETPLACE")**

A governmental agency or non-profit entity that meets the applicable Exchange standards, and other related standards established under the Affordable Care Act (ACA), and makes Qualified Health Plans (QHP) available to Qualified Individuals and qualified employers. Unless otherwise identified, this term refers to State Exchanges, regional Exchanges, subsidiary Exchanges, and a Federally-facilitated Exchange on which Blue Cross and Blue Shield of Oklahoma offers this QHP.

## **EXPERIMENTAL/INVESTIGATIONAL/UNPROVEN**

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

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

## **GENERIC DRUG**

A drug that has the same active ingredient as a brand-name drug and is allowed to be produced after the brand-name drug's patent has expired. In determining the brand or generic classification for Covered Drugs, the Plan uses the generic/brand status assigned by a nationally recognized provider of drug product database information. A list of Preferred Generic Drugs and Non-Preferred Generic Drugs is available on the Plan's Web site at [www.bcbsok.com](http://www.bcbsok.com). You may also contact a Customer Service Representative at the number shown on your Identification Card for more information.

## **GENERIC PLUS DRUG LIST**

A sample listing of the most commonly prescribed medications available in the Generic Drug and Preferred Brand Drug categories. This list is developed using monographs written by the American Medical Association, Academy of Managed Care Pharmacies, and other pharmacy and medical related organizations, describing clinical outcomes, drug efficacy, and side effect profiles.

## **HOME HEALTH CARE AGENCY**

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

## **HOSPICE**

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

## **HOSPITAL**

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

- Is licensed;
- Mainly provides Inpatient diagnostic and therapeutic services under the supervision of Physicians;
- Has organized departments of medicine and major Surgery;
- Provides 24-hour nursing service; and
- Is not, other than incidentally, a:
  - Skilled Nursing Facility;
  - Nursing home;
  - Custodial Care home;
  - Health resort;
  - Spa or sanitarium;
  - Place for rest;
  - Place for the aged;
  - Place for the treatment of Mental Illness;
  - Place for the treatment of substance abuse or chemical dependency;
  - Place for the provision of Hospice care;
  - Place for the provision of rehabilitation care; or
  - Place for the treatment of pulmonary tuberculosis.

## **HOSPITAL ADMISSION**

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

## **IDENTIFICATION CARD**

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

## **INDIVIDUAL HEALTH INSURANCE COVERAGE**

Health insurance coverage offered to individuals in the individual market, but not including short-term, limited-duration insurance. Individual Health Insurance Coverage can include Dependent coverage.

### **INPATIENT**

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

### **INTENSIVE OUTPATIENT TREATMENT**

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

### **LICENSED PRACTICAL OR VOCATIONAL NURSE (LPN OR LVN)**

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

### **MAINTENANCE PRESCRIPTION DRUG**

A Prescription Drug prescribed for chronic conditions and which is taken on a regular basis to treat conditions such as high cholesterol, high blood pressure or asthma.

### **MATERNITY SERVICES**

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

### **MEDICAL CARE**

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

### **MEDICALLY NECESSARY (OR MEDICAL NECESSITY)**

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

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

### **MEDICARE**

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

### **MEMBER**

An Eligible Person who has enrolled for coverage.

## **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.

## **MINIMUM ESSENTIAL COVERAGE**

Health insurance coverage that is recognized as coverage that meets substantially all requirements under applicable law pertaining to adequate individual, group or government health insurance coverage. Loss of Minimum Essential Coverage does not include termination of coverage for failure to pay premiums or as a result of a rescission. For additional information on whether particular coverage is recognized as Minimum Essential Coverage, please call the Customer Service number shown on the back of your Identification Card or visit [www.cms.gov](http://www.cms.gov).

## **NETWORK PROVIDER**

A Provider who has entered into a Participating Provider Agreement with the Plan to bill the Plan directly for Covered Services, and to accept the Plan's Allowable Charge as payment for such Covered Services. Network Providers include BlueCard Providers outside the state of Oklahoma.

## **NETWORK SERVICE AREA**

The geographic area designated by the Plan, within which the Benefits of this Contract are available to Subscribers. A Subscriber may call the Customer Service Department at the number shown on the Identification card to determine if he or she is in the Network Service Area or visit the Web site at [www.bcsok.com](http://www.bcsok.com).

## **NON-PREFERRED BRAND DRUG**

A name-brand Prescription Drug which appears on the applicable Drug List and is subject to the Non-Preferred Brand Drug Copayment amount and/or Coinsurance amount designated in the *Schedule of Benefits for Outpatient Prescription Drugs and Related Services*.

## **OKLAHOMA RESIDENT**

A person domiciled in the state of Oklahoma. "Domicile" is the place established as your true, fixed and permanent home. It is the place you intend to return to whenever you are away (as on vacation abroad, business assignment, education leave or military assignment). A domicile, once established, remains until a new one is adopted.

## **ORTHOGNATHIC SURGERY**

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

## **OUT-OF-NETWORK PHARMACY**

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

## **OUT-OF-NETWORK PROVIDER**

A Provider that has not entered into an agreement with the Plan to be a Network Provider or BlueCard Provider.

## **OUT-OF-POCKET LIMIT**

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

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

## **OUTPATIENT**

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

## **PARTICIPATING PHARMACY**

An independent retail Pharmacy, chain of retail Pharmacies, mail-order Pharmacy or specialty Pharmacy that has entered into a written agreement with the Plan, or other entity chosen by the Plan to administer its Prescription Drug program, to provide pharmaceutical services to you at the time you receive the services.

To find a Pharmacy in the Participating Pharmacy, please refer to the Plan's Web site at [www.bcbsok.com](http://www.bcbsok.com) or call a Customer Service representative at the number shown on your Identification Card.

## **PARTICIPATING SPECIALTY PHARMACY**

A Pharmacy that has entered into an agreement to be a part of the Plan's Specialty Pharmacy Network.

## **PHARMACY**

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

## **PHYSICIAN**

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

## **PLACEMENT FOR ADOPTION (OR PLACED FOR ADOPTION)**

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

## **PLAN**

Blue Cross and Blue Shield of Oklahoma.

## **POLICY YEAR**

The 12-month period beginning January 1 each year.

## **PREAUTHORIZATION**

The process that determines in advance the Medical Necessity or Experimental, Investigational or Unproven nature of certain care and services under the Contract.

Preauthorization does not guarantee that the care and services you receive are eligible for Benefits under the Contract. At the time your claims are submitted, they will be reviewed in accordance with the terms of the Contract.

## **PREFERRED BRAND DRUG**

A brand-name drug which appears on the applicable Drug List and is subject to the Preferred Brand Drug Copayment amount and/or Coinsurance amount designated in the *Schedule of Benefits for Outpatient Prescription Drugs and Related Services*.

## **PRESCRIPTION DRUG**

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

## **PRESCRIPTION ORDER**

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

## **PREVENTIVE CARE SERVICES**

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

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

## **PROPERLY FILED CLAIM**

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

## **PROVIDER**

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

## **PSYCHIATRIC HOSPITAL**

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

## **QUALIFIED HEALTH PLAN ("QHP")**

A health care benefit program that has in effect a certification that it meets the applicable standards issued or recognized by the Exchange through which such program is offered.

## **REGISTERED NURSE (RN)**

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

## **RESIDENTIAL TREATMENT CENTER**

A state licensed and/or state certified facility that provides a 24-hour level of residential care to patients with long-term or severe Mental Illnesses and/or substance abuse disorders. This care is medically monitored, with 24-hour Physician availability and 24-hours onsite nursing services. It does not include half-way houses, supervised living, group homes, boarding houses or other facilities that provide primarily a supportive environment and address long-term social needs.



### **RETAIL HEALTH CLINIC**

A health care clinic located in a retail setting, supermarket or Pharmacy which provides treatment of common illnesses and routine preventive health care services rendered by a Physician or other Provider.

### **RETAIL PHARMACY VACCINATION NETWORK**

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

### **ROUTINE NURSERY CARE**

Ordinary Hospital nursery care of the newborn Subscriber.

### **SKILLED NURSING FACILITY**

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

- Custodial Care, ambulatory, or part-time care; or
- Treatment for Mental Illness, substance abuse, chemical dependency or pulmonary tuberculosis.

### **SPECIALIST**

A Physician who provides medical services in any generally accepted medical specialty or sub-specialty, or a Physician licensed in any duly recognized special healing arts discipline who provides health care and services generally accepted within the scope of the Physician's license.

### **SPECIALTY PHARMACY DRUGS**

Prescription Drugs that are high cost and generally prescribed for use in limited patient populations or indications. These drugs are typically injected, but may also include high cost oral medications. In addition, patient support and/or education and special dispensing or delivery may be required for these drugs; therefore, they are difficult to obtain via traditional pharmacy channels. A considerable portion of the use and costs are frequently generated through office-based medical claims and may require complex reimbursement procedures. The list of Specialty Drugs is subject to change. To determine which drugs are Specialty Drugs, you should contact your Pharmacy, refer to the Drug List at [www.bcbsok.com](http://www.bcbsok.com) or call the Customer Service toll-free number on your Identification Card.

### **SPECIALTY PHARMACY NETWORK**

A limited network of Participating Pharmacies that provide the following services to Subscribers:

- access to high-cost medications that are used in limited populations;
- special dispensing, delivery and patient clinical support;
- guidance through complex reimbursement procedures for Specialty Pharmacy Drugs.

### **SUBSCRIBER**

The Member and each of his/her Dependents (if any) enrolled under this Contract.

### **SURGERY**

- The performance of generally accepted operative and other invasive procedures;

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- The correction of fractures and dislocations;
- Usual and related preoperative and postoperative care.

## **THERAPY SERVICE**

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

- **Radiation Therapy** – the treatment of disease by x-ray, radium, or radioactive isotopes.
- **Chemotherapy** – the treatment of malignant disease by chemical or biological antineoplastic agents, but not including High-Dose Chemotherapy. High-Dose Chemotherapy is specifically addressed in certain sections under “Human Organ, Tissue and Bone Marrow Transplant Services.”
- **Respiratory Therapy** – introduction of dry or moist gases into the lungs for treatment purposes.
- **Dialysis Treatment** – the treatment of an acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body to include hemodialysis or peritoneal dialysis.
- **Physical Therapy** – the treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles, and devices to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of body part.
- **Speech Therapy** – treatment for the correction of a speech impairment resulting from disease, Surgery, injury, congenital and developmental anomalies, or previous therapeutic processes.
- **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.

## **TOBACCO USER**

A person who is permitted under state and federal law to legally use tobacco, with tobacco use (other than religious or ceremonial use of Tobacco) on average four or more times per week that last occurred within the past six months (or such other meaning required or permitted by applicable law). Tobacco includes, but is not limited to: cigars, smokeless tobacco, snuff, electronic cigarettes, etc. For additional information, please call the number on the back of your Identification Card or visit our Web site at [www.bcbsok.com](http://www.bcbsok.com).

## **TOTAL DISABILITY (OR TOTALLY DISABLED)**

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

- The Subscriber is unable to perform the substantial duties of any occupation or business for which he/she is qualified and the Subscriber is not in fact engaged in any occupation for wages or profit; or
- If the Subscriber does not usually work for wages or profit, the Subscriber cannot do the normal activities of a person of the same age and sex.

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

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**NOTICE OF  
PROTECTION PROVIDED BY  
OKLAHOMA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION**

This notice provides a brief summary of the Oklahoma Life and Health Insurance Guaranty Association (“the Association”) and the protection it provides for policyholders. This safety net was created under Oklahoma law, which determines who and what is covered and the amounts of coverage. The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Oklahoma law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- Life Insurance
  - \$300,000 in death benefits
  - \$100,000 in cash surrender or withdrawal values
- Health Insurance
  - \$500,000 in hospital, medical and surgical insurance benefits
  - \$300,000 in disability income insurance benefits
  - \$300,000 in long-term care insurance benefits
  - \$100,000 in other types of health insurance benefits
- Annuities
  - \$300,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is \$300,000, except that with regard to hospital, medical and surgical insurance benefits, the maximum amount that will be paid is \$500,000.

**Note: Certain policies and contracts may not be covered or fully covered.** For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Oklahoma law.

To learn more about the above protections, please visit the Association’s website at [www.oklifega.org](http://www.oklifega.org), or contact:

Oklahoma Life & Health Insurance Guaranty Association  
201 Robert S. Kerr, Suite 600  
Oklahoma City, OK 73102  
Phone: (405) 272-9221

Oklahoma Department of Insurance  
3625 NW 56th Street, Suite 100  
Oklahoma City, OK 73112  
1-800-522-0071 or (405) 521-2828

**Insurance companies and agents are not allowed by Oklahoma law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Oklahoma law, then Oklahoma law will control.**

This certificate is only a representative sample and does not constitute an actual insurance policy or contract.

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**1400 South Boston  
P. O. Box 3283  
Tulsa, OK 74102-3283  
1-866-520-2507**

Sample

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,  
an Independent Licensee of the Blue Cross and Blue Shield Association  
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