BlueCross BlueShield of Oklahoma

Your Health Care Benefits Program

OK-GP-PPO-22

Blue Choice Gold PPO℠ 202

Blue Choice PPO℠ Network

Schedule of Benefits for Comprehensive Health Care Services

This schedule shows the Deductibles, Copayments and/or Coinsurance amounts that apply to Covered Services described in the ***Comprehensive Health Care Services*** section of your Certificate**.** Deductibles, Copayments, Coinsurance amounts and Out-of-Pocket Limits may be subject to change or increase as permitted by applicable law. **All Inpatient services and many Outpatient services require Prior Authorization approval from the Plan, as set forth in your Certificate. Please note that services must be Medically Necessary, as determined by the Plan, in order to be covered.**

BENEFIT PERIOD	Calendar Year
NETWORK PROVIDERS	To receive maximum Benefits under your Certificate, you must receive services from Blue Choice Providers in Oklahoma or BlueCard Providers outside the state of Oklahoma. Refer to www.bcbsok.com or call a Customer Service Representative at the number shown on your Identification Card to find a Network Provider near you.
COPAYMENTS	
Office Visit Copayments	The following Copayments will apply: • $40 for each Network Provider's office visit, Retail Health Clinic visit or Virtual Visit. • $40 for each Network Provider's office visit or Virtual Visit for Psychiatric Care Services. • $65 for each visit to a Network Specialist's office. • $50 for each visit to a Network Urgent Care facility or provided by a Network Urgent Care Provider. NOTE: For Covered Maternity Services. Copayment applies to initial prenatal visit only (per pregnancy). The Copayment applies to charges which are billed as part of the visit, except for: • Preventive Care Services received from a Network Provider; • Annual mammography screening; • Covered childhood immunizations (for Subscribers under age 19); • Surgical services; • Outpatient Diagnostic Services; • Physical Therapy, Occupational Therapy and Speech Therapy. **Copayments do not apply to services received from Out-of-Network Providers.** **Allowable Charges *are not* subject to the Benefit Period Deductible or Coinsurance.**
Outpatient Infusion Therapy Copayment (maintenance drugs)	• $50 for Outpatient Infusion Therapy performed in a Network Physician's office, infusion suite or in the home. • $500 for Outpatient Infusion Therapy performed in a Network Outpatient facility. **Allowable Charges *are not* subject to the Benefit Period Deductible or Coinsurance.** ***Copayment does not apply for non-maintenance drugs. Outpatient Infusion Therapy for non-maintenance drugs is subject to the Benefit Period Deductible and Coinsurance.**
Emergency Room Copayment	$500 for each visit to a Hospital emergency room. This Copayment is waived if you are admitted to the Hospital through the emergency room visit. **In addition to the Copayment, the remaining Allowable Charges *are* subject to the Benefit Period Deductible and Coinsurance.**

Outpatient Surgery Copayment	• $200 for each visit to a Network Outpatient facility for Surgery. This Copayment applies to surgical procedures received in a Hospital Outpatient department, Ambulatory Surgical Facility or other freestanding Outpatient facility. • $300 for each visit to an Out-of-Network Outpatient facility for Surgery. This Copayment applies to surgical procedures received in an Out-of-Network Hospital Outpatient department, Ambulatory Surgical Facility or other freestanding Outpatient facility. **In addition to the Copayment, the remaining Allowable Charges *are* subject to the Benefit Period Deductible and Coinsurance.**
Inpatient Per Admission Copayment	• $250 for each Network Hospital Admission or Hospice admission. • $350 for each Out-of- Network Hospital Admission or Hospice admission. **In addition to the Copayment, the remaining Allowable Charges *are* subject to the Benefit Period Deductible and Coinsurance.**
BENEFIT PERIOD DEDUCTIBLE	• **Network Provider Services –** $2,500 per Benefit Period per Subscriber, or $7,500 for all covered family members combined. • **Out-of-Network Provider Services –** $5,000 per Benefit Period per Subscriber, or $15,000 for all covered family members combined. Deductible amounts for Network Provider Services and Out-of-Network Provider Services ***do not*** cross-apply. The Benefit Period Deductible is in addition to the Outpatient Infusion Therapy Copayment, Emergency Room Copayment, Inpatient Per Admission Copayment, and Outpatient Surgery Copayment described above. The Benefit Period Deductible applies to all Covered Services, except: • Network Provider services that are subject to the Office Visit Copayment. • Network Provider services that are subject to the Outpatient Infusion Therapy Copayment (maintenance drugs). • Preventive Care Services received from a Network Provider. Preventive Care Services received from an Out-of-Network Provider are subject to Deductible, except for: – Annual mammography screening; – Annual prostate cancer screening; – Covered childhood immunizations (for Subscribers under age 19); – Any other state or federally mandated Benefits which stipulate a Deductible may not be required.
OUT-OF-POCKET LIMIT	• **Network Provider Services** – $4,000 per Subscriber, or $12,000 for all covered family members combined. When this limit has been paid (including any Copayment and/or Deductible amounts) for Covered Services provided by Network Providers during a Benefit Period, the amount of Allowable Charges covered by the Plan for such Subscriber will increase to 100% during the remainder of the Benefit Period for Covered Services received from Network Providers. • **Out-of-Network Provider Services** – Unlimited. Out-of-Pocket Limits for Network Provider Services and Out-of-Network Provider Services ***do not*** cross-apply. This Out-of- Pocket Limit does not include any of the following: • Services, supplies or charges limited or excluded by this Certificate; • Expenses not covered because a Benefit maximum has been reached; • Any penalty incurred due to your failure to follow the Plan's requirements for Prior Authorization, as set forth in the Certificate.

BENEFIT PERCENTAGE AMOUNT	The following chart shows the percentage of Allowable Charges covered by this Certificate through payments and/or contractual arrangements with Providers. These percentages apply only after your Deductibles and/or Copayment amounts have been satisfied. **NOTE: Any services classified as "Preventive Care Services" are paid at 100% of the Allowable Charge and are not subject to Deductibles, Copayments and/or Coinsurance, provided such services are received from Network Providers.**

COVERED SERVICES (Subject to the *Comprehensive Health Care Services* section)		
	BENEFIT PERCENTAGE OF ALLOWABLE CHARGES COVERED BY THE PLAN	
	Network Provider Services	**Out-of-Network Provider Services**
PREVENTIVE CARE SERVICES		
Annual Mammography Screening	100%	100%
Covered Childhood Immunizations	100%	100%
All Other Covered Preventive Care Services	100%	70%
EMERGENCY CARE SERVICES[1]	80%	80%
THE FOLLOWING BENEFIT PERCENTAGES APPLY TO SERVICES THAT ARE NOT CLASSIFIED AS PREVENTIVE CARE SERVICES OR EMERGENCY CARE SERVICES, AS DETERMINED BY THE PLAN		
HOSPITAL SERVICES[2]	80%	60%
SURGICAL/MEDICAL SERVICES[2]		
Physician's Office Visit/Retail Health Clinic Visit/ Virtual Visit/Urgent Care Visit	100%[3]	70%
All Other Covered Surgical/Medical Services	80%	60%
OUTPATIENT DIAGNOSTIC SERVICES[2]	80%	60%
OUTPATIENT THERAPY SERVICES[2] Maximum of 25 Outpatient visits for Physical Therapy, Occupational Therapy and Speech Therapy (combined) per Benefit Period[4], except for "Services Related to Treatment of Autism and Autism Spectrum Disorders" as specified in this Certificate	80%	60%[5]
OUTPATIENT INFUSION THERAPY SERVICES[2]		
Outpatient Infusion Therapy (maintenance drugs)	100%[6]	70%
Outpatient Infusion Therapy (non-maintenance drugs)	80%	60%
MATERNITY SERVICES[7]	80%	60%

[1] See the Certificate for details regarding "Emergency Care Services".

[2] All Inpatient services and certain Outpatient services are subject to Prior Authorization approval from the Plan. See the Certificate for details regarding "Prior Authorization" requirements.

[3] Applicable only to Covered Services which are subject to the Office Visit Copayment. For services which are not subject to the Office Visit Copayment, this percentage amount is reduced to 80% of Allowable Charges after satisfaction of the Deductible.

[4] Separate 25-visit maximums will apply to Outpatient Rehabilitation Care and Outpatient Habilitation Care.

[5] You must obtain Prior Authorization approval from the Plan before you receive Outpatient Dialysis Treatment from an Out-of-Network Provider. See the Certificate for details regarding "Prior Authorization" requirements.

[6] Subject to Copayment based on place of treatment.

[7] Copayment applies to initial prenatal visit (per pregnancy) to a Network Provider. Deductible and Coinsurance apply to subsequent visits and to all Out-of-Network Provider Services.

COVERED SERVICES (Subject to the *Comprehensive Health Care Services* section)		
	BENEFIT PERCENTAGE OF ALLOWABLE CHARGES COVERED BY THE PLAN	
	Network Provider Services	**Out-of-Network Provider Services**
MASTECTOMY AND RECONSTRUCTIVE SURGICAL SERVICES[1]	80%	60%
HUMAN ORGAN, TISSUE AND BONE MARROW TRANSPLANT SERVICES[1]	80%	60%
AMBULATORY SURGICAL FACILITY SERVICES	80%	60%[1]
SERVICES RELATED TO TREATMENT OF AUTISM AND AUTISM SPECTRUM DISORDERS	80%	60%
PSYCHIATRIC CARE SERVICES[1]		
Physician's Office Visit/Retail Health Clinic Visit/ Virtual Visit	100%[2]	70%
All Other Covered Psychiatric Care Services	80%	60%
AMBULANCE SERVICES	80%	80%
PRIVATE DUTY NURSING SERVICES[1] 85-visit maximum per Benefit Period	80%	60%
REHABILITATION CARE AND HABILITATION CARE[1] 30-day maximum per Benefit Period for Inpatient care[3]	80%	60%
SKILLED NURSING FACILITY SERVICES[1] 30-day maximum per Benefit Period	80%	60%
HOME HEALTH CARE SERVICES[1] 30-visit maximum per Benefit Period	80%	60%
HOSPICE SERVICES[1]	80%	60%
DENTAL SERVICES FOR ACCIDENTAL INJURY	80%	60%
DIABETES EQUIPMENT, SUPPLIES AND SELF-MANAGEMENT SERVICES	80%	60%
SERVICES RELATED TO CLINICAL TRIALS	80%	60%
DURABLE MEDICAL EQUIPMENT	80%	60%
PROSTHETIC APPLIANCES	80%	60%
ORTHOTIC DEVICES Maximum of 15 per Benefit Period	80%	60%
WIGS OR OTHER SCALP PROSTHESES Maximum of One per Benefit Period	80%	60%
ALL OTHER COVERED SERVICES	80%	60%

[1] *All Inpatient services and certain Outpatient services are subject to Prior Authorization approval from the Plan. See the Certificate for details regarding "Prior Authorization" requirements.*

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

[3] *Separate 30-day maximums will apply to Inpatient Rehabilitation Care and Inpatient Habilitation Care.*

Blue Choice Gold PPO℠ 202
Schedule of Benefits
for Outpatient Prescription Drugs and Related Services

This schedule shows any Deductible, Copayment and/or Coinsurance amounts that apply to the Covered Services described in the ***Outpatient Prescription Drugs and Related Services*** section of your Certificate. Deductibles, Copayments, Coinsurance amounts and Out-of-Pocket Limits may be subject to change or increase as permitted by applicable law. **Please note that services must be Medically Necessary, as determined by the Plan, and must be included on the Drug List in order to be covered.**

BENEFIT PERIOD	Calendar Year
DEDUCTIBLE	None. Your Benefits for Outpatient Prescription Drugs and related services are not subject to the Benefit Period Deductible set forth in the ***Schedule of Benefits for Comprehensive Health Care Services.***
OUT-OF-POCKET LIMIT	• Your Benefits for Outpatient Prescription Drugs and related services purchased at a Participating Pharmacy or Specialty Network Pharmacy are subject to the Out-of-Pocket Limit for "Network Provider Services" set forth in the ***Schedule of Benefits for Comprehensive Health Care Services.*** • Your Benefits for Outpatient Prescription Drugs and related services purchased at an Out-of-Network Pharmacy or any Pharmacy other than a Specialty Network Pharmacy are subject to the Out-of-Pocket Limit for "Out-of-Network Provider Services" set forth in the ***Schedule of Benefits for Comprehensive Health Care Services.***
COPAYMENT/COINSURANCE	The Copayment/Coinsurance amount applicable to each Prescription Order is set forth below.

Any Deductible, Copayment and Coinsurance amounts for Prescription Orders filled at a Participating Pharmacy or Specialty Network Pharmacy will accumulate toward satisfaction of your Out-of-Pocket Limit for "Network Provider Services".

When Prescription Orders are filled at an Out-of-Network Pharmacy or any Pharmacy other than a Specialty Network Pharmacy, the following provisions apply:

- you are responsible for 50% of Allowable Charges, plus the applicable Copayment or Coinsurance shown below. Only the Copayment or Coinsurance will accumulate toward satisfaction of your Out-of-Network Out-of-Pocket Limit; and
- in addition, to your Copayment and/or Coinsurance amounts, 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: The amount you may pay for a covered insulin drug shall not exceed $30 per 30-day supply or $90 per 90-day supply.

	Copayment/Coinsurance Amounts per Prescription Order For Which You Are Responsible		
Retail Pharmacy Program (30-Day Supply)	**Preferred Participating Pharmacy**	**Participating Pharmacy**	**Out-of-Network Pharmacy[1]**
Tier 1	$10 Copayment	$20 Copayment	$20 Copayment plus 50% of Allowable Charges
Tier 2	$20 Copayment	$30 Copayment	$30 Copayment plus 50% of Allowable Charges
Tier 3	$50 Copayment	$70 Copayment	$70 Copayment plus 50% of Allowable Charges
Tier 4	$100 Copayment	$120 Copayment	$120 Copayment plus 50% of Allowable Charges

		Copayment/Coinsurance Amounts per Prescription Order For Which You Are Responsible	
Extended Prescription Drug Supply Program (90-Day Supply)	**Quantity Dispensed**	**Participating Extended Supply Pharmacy**	**Any Pharmacy other than a Participating Extended Supply Pharmacy**
Tier 1	1 to 30 days	$10 Copayment	Not Covered
	31 to 60 days	$20 Copayment	Not Covered
	61 to 90 days	$30 Copayment	Not Covered
Tier 2	1 to 30 days	$20 Copayment	Not Covered
	31 to 60 days	$40 Copayment	Not Covered
	61 to 90 days	$60 Copayment	Not Covered
Tier 3	1 to 30 days	$50 Copayment	Not Covered
	31 to 60 days	$100 Copayment	Not Covered
	61 to 90 days	$150 Copayment	Not Covered
Tier 4	1 to 30 days	$100 Copayment	Not Covered
	31 to 60 days	$200 Copayment	Not Covered
	61 to 90 days	$300 Copayment	Not Covered

[1] *In addition to any Copayment and/or Coinsurance amounts, you are also responsible for any charges which exceed the Allowable Charges determined by the Plan.*

	Copayment/Coinsurance Amounts per Prescription Order For Which You Are Responsible	
Mail-Order Pharmacy Program (90-Day Supply)	**Participating Mail-Order Pharmacy**	**Any Pharmacy other than the Participating Mail-Order Pharmacy**
Tier 1	$30 Copayment	Not Covered
Tier 2	$60 Copayment	Not Covered
Tier 3	$150 Copayment	Not Covered
Tier 4	$300 Copayment	Not Covered

	Copayment/Coinsurance Amounts per Prescription Order For Which You Are Responsible	
Specialty Pharmacy Program (30-Day Supply)	**Specialty Network Pharmacy**	**Any Pharmacy other than a Specialty Network Pharmacy**[1]
Tier 5	$150 Copayment	$150 Copayment plus 50% of Allowable Charges
Tier 6	$250 Copayment	$250 Copayment plus 50% of Allowable Charges

Brand Name Drug Selection

If you receive a Brand Name Drug when a Generic Drug equivalent is available, you will be responsible for the difference between the Allowable Charge for the Brand Name Drug and the Allowable Charge for the Generic Drug equivalent. This amount is in addition to any Deductible, Copayment and/or Coinsurance amount set forth in this ***Schedule of Benefits.***

Exceptions to this provision may be allowed for certain preventive medications (including prescription contraceptive medications) if your health care Provider submits a request to the Plan indicating that the Generic Drug would be medically inappropriate, along with supporting documentation. If the Plan grants the exception request, any difference between the Allowable Charge for the Brand Name Drug and the Generic Drug equivalent will be waived.

Prescription Drug List

The Drug List is available on the Plan's Web site at www.bcbsok.com. This list shows many commonly prescribed and clinically useful Generic Drugs and Brand Drugs to provide coverage for a broad range of diseases. Brand Drugs may be included when a Generic Drug is not available to treat a specific medical condition or the Brand Drug offers a significant advantage over available Generic Drugs as determined by the Plan. This listing is maintained by a committee, which is made up of current and previously practicing Physicians and pharmacists from across the country, some of whom are employed by or affiliated with Blue Cross and Blue Shield. You may call a Customer Service Representative to request an updated listing at the number shown on your Identification Card.

[1] *In addition to any Copayment and/or Coinsurance amounts, you are also responsible for any charges which exceed the Allowable Charges determined by the Plan*.

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Certificate

This Certificate is issued according to the terms of your Group Health Plan.

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

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

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

are covered by this Certificate. Covered persons are called Subscribers (or you, your).

Any reference to "applicable law" will include applicable laws and rules, including, but not limited to, statutes, ordinances and administrative decisions and regulations.

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

President of Blue Cross and Blue Shield of Oklahoma

Your Subscriber Identification Number:

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

Important Information

PLEASE READ THIS SECTION CAREFULLY! It explains the role the Blue Cross and Blue Shield of Oklahoma Provider networks play in your health care coverage. It also explains important cost containment features in your health care 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. The Plan has negotiated special agreements with Hospitals, Outpatient facilities, Physicians and other health care professionals from many specialties. These participating health care Providers work with the Plan 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.

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, the coverage offers considerable financial advantages to Subscribers who choose to use a Network Provider.

This coverage operates around a group of Hospitals, Physicians and other Providers who have agreed to accept no more than a reasonable, predetermined fee for their services. When 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 and out-of-network Prior Authorization requirements may apply to your coverage. Refer to the Schedule of Benefits in the front of this Certificate 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 the 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 Certificate. If your Physician prescribes these services, request that he/she refer you to a Network or BlueCard Provider whenever possible.

If Benefits are provided at a participating Hospital, at a participating Surgery center or other participating treatment center, any Benefits provided by a non-participating anesthesiologist (including a certified registered nurse anesthetist), pathologist, radiologist, or emergency room Physician, assistant surgeon (if the primary surgeon is a Network Provider) or other Hospital-based Physician, the Subscriber will incur no greater out-of-pocket costs than would have been incurred if the Benefits were provided by a Network Provider, except that the non-participating Provider may bill the Subscriber for the difference between payment by the Plan and the Provider charges plus in-network Deductible, Copayment and/or Coinsurance. Please call Customer Service if you have any questions about the Benefits described in this section or how your claims have been processed.

COST SHARING FEATURES OF YOUR COVERAGE

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

A Tobacco User may be subject to a premium increase 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 to prevent or reduce Tobacco Use, if required by applicable law.

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. 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 Certificate when you use a Network Provider.

THE BLUECARD® PROGRAM

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

- **Finding a Physician or Hospital**

  When you're outside of Oklahoma and you need to find information about a Blue Cross and Blue Shield Physician or Hospital, just call the BlueCard Doctor and Hospital Information Line at 1-800-810-BLUE (2583), or you may refer to the BlueCard Doctor and Hospital Finder at http://www.bluecares.com. We will help you locate the nearest Network Physician or Hospital. *Remember, you are responsible for receiving Prior*

Authorization, if applicable, from Blue Cross and Blue Shield of Oklahoma. As always, in case of an emergency, you should seek immediate care from the closest health care Provider.

- **Available Care Coast to Coast**

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

- **Remember to Always Carry the BlueCard**

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

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

NOTE: Blue Cross and Blue Shield of Oklahoma may postpone application of any Deductible, Copayment and/or Coinsurance amounts whenever it is necessary in order to obtain Provider discounts for Covered Services you receive outside the state of Oklahoma.

HOW THE BLUECARD PROGRAM WORKS

✓ You're outside the state of Oklahoma and need health care.

✓ Call 1-800-810-BLUE (2583) for information on the nearest PPO Physicians and Hospitals or visit the BlueCard Web site at http://www.bluecares.com.

✓ You are responsible for Prior Authorization, 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 Preferred 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. 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 Blue Cross and Blue Shield of Oklahoma 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 Preferred 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 Certificate, unless coverage is specifically provided elsewhere in this Certificate and/or is required by applicable law or regulation. Please refer to the Plan's Web site at 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 the Benefits available under this Certificate.

UTILIZATION MANAGEMENT

Utilization management may be referred to as Medical Necessity reviews, utilization review (UR) or medical management reviews. Medical Necessity reviews may occur when a Provider requests an authorization prior to services rendered, during the course of care, or after care has been completed for a Post-Service Medical Necessity Review. However, some services may require a Prior Authorization before the start of services.

Types of Utilization Management:

- Prior Authorization;
- Predetermination; and
- Post-Service Medical Necessity Reviews.

Refer to the definition of Medically Necessary in the *Definitions* section of this Certificate for additional information regarding any limitations and/or special conditions pertaining to your Benefits.

You may incur a Benefit reduction if you fail to obtain Prior Authorization for these Covered Services. The Covered Services and Prior Authorization rules that impact them are described in the provision entitled *"Failure to Obtain Prior Authorization."*

PRIOR AUTHORIZATION

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

You are responsible for satisfying the requirements for *"Prior Authorization"*. This means that you must request Prior Authorization or assure that your Physician, Provider of services, or an authorized representative complies with the **requirements** below. Failure to Obtain Prior Authorization before receiving services may result in a reduction in Benefits as described below under *"Failure to Obtain Prior Authorization."*

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

- **Prior Authorization Process for Inpatient Services**

  For an Inpatient facility stay, *you must request Prior Authorization from the Plan as soon as possible, but no later than one business day* ***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 Prior Authorization, your Benefits under this Certificate will be reduced, as described below under *"Failure to Obtain Prior Authorization"*, 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. For Inpatient services received outside of our service area, see the section entitled, "The BlueCard® Program" in ***General Provisions***.

  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).

- **Prior Authorization Process for Inpatient Psychiatric Care Services**

  All **Inpatient** services (including partial hospitalization programs), related to treatment of Mental Health and Substance Use Disorder must obtain Prior Authorization by the Plan.

- **Prior Authorization Requests Involving Emergency Care**

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

- **Prior Authorization Process for Certain Outpatient Services**

  You must request Prior Authorization from the Plan at least two business days prior to receiving any of the following **Outpatient** services:

  — Outpatient Surgery performed at a Hospital or Ambulatory Surgical Facility (Out-of-Network Services only);

  — Dialysis Treatment (Out-of-Network Services only);

  — Molecular genetic testing;

  — Radiation Therapy;

  — Home Infusion Therapy;

- Human Organ and Tissue Transplant services;
- Private Duty Nursing Services;
- Hospice Services;
- Home Hemodialysis;
- Home Health Care Services;
- Outpatient Provider administered drug therapies, Cellular Immunotherapy, Gene Therapy, and select medical benefit drug therapies, Specialty Drug Therapy, and Outpatient Infusions;
- Applied Behavior Analysis; and
- Any of the following Psychiatric Care Services:
    - Psychological testing;
    - Neuropsychological testing;
    - Electroconvulsive therapy;
    - Intensive Outpatient Treatment;
    - Repetitive Transcranial Magnetic Stimulation.

The following additional Outpatient procedures/services:

- **Cardiac (heart related):**
    - Lipid Apheresis.
- **Ears, Nose and Throat (ENT):**
    - Bone Conduction Hearing Aids;
    - Cochlear Implant;
    - Nasal and Sinus Surgery.
- **Gastroenterology (Stomach):**
    - Gastric Electrical Stimulation (GES).
- **Neurological:**
    - Deep Brain Stimulation;
    - Sacral Nerve Neuromodulation/Stimulation;
    - Vagus Nerve Stimulation (VNS).
- **Orthopedic (Musculoskeletal):**
    - Artificial Intervertebral Disc;
    - Autologous Chondrocyte Implantation (ACI) for Focal Articular Cartilage Lesions;
    - Femoroacetabular Impingement (FAI) Syndrome;
    - Joint and Spine Surgery;
    - Lumbar Spinal Fusion;
    - Meniscal Allografts and Other Meniscal Implants;
    - Orthopedic Applications of Stem-Cell Therapy.

— **Pain Management:**
  - Occipital Nerve Stimulation;
  - Surgical Deactivation of Headache Trigger Sites;
  - Interventional Pain Management;
  - Percutaneous and Implanted Nerve Stimulation and Neuromodulation;
  - Spinal Cord Stimulation.

— **Radiology:**
  - Advanced Imaging Services: MRI, Magnetic Resonance Angiogram (MRA), PET, PET-CT, CT, Computed Tomography Angiography (CTA), Nuclear Medicine.

— **Surgical Procedures:**
  - Orthognathic Surgery; Face reconstruction;
  - Mastopexy; Breast lift;
  - Reduction Mammoplasty; Breast Reduction.

— **Wound Care:**
  - Hyperbaric Oxygen (HBO2) Therapy -Systemic.

For specific details about the Prior Authorization requirement for the above referenced services, please call the Customer Service number on the back of your Identification Card. The complete list of Covered Services requiring Prior Authorization is subject to review and change by Blue Cross and Blue Shield of Oklahoma. The Plan reserves the right to no longer require Prior Authorization during the Benefit Period for any or all the above listed Outpatient services.

The Plan will send a letter to you, your Physician and the Hospital or facility with a determination of your Prior Authorization review no later than fifteen (15) calendar days after Blue Cross and Blue Shield receives the request for Prior Authorization review. However, in some instances depending on the timing of the request for review, these letters will not be received prior to your scheduled date of service or procedure.

- **Failure to Obtain Prior Authorization**

  If neither you nor your Provider request Prior Authorization for Inpatient services, your coverage will be subject to a $500 reduction in Benefits. If, upon receipt of a claim, it is determined that any services you received were not Medically Necessary or were Experimental, Investigational and/or Unproven, it may be your responsibility to pay the full cost of the services received.

- **Response to Prior Authorization Requests**

  The Plan will provide a written response to your Prior Authorization 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 *Prior Authorization* within 15 days following receipt of the additional information.

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

- **Response to Prior Authorization Requests Involving Urgent Care**

  A *"Prior Authorization Request Involving 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

  — 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 Prior Authorization 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 *"Prior Authorization Request Involving Urgent Care"*, including an adverse determination, if applicable, may be issued orally. A written notice will also be provided within three days following the oral notification.

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

LENGTH OF STAY/SERVICE REVIEW

Length of stay/service review is not a guarantee of Benefits. Actual availability of Benefits is subject to eligibility and the other terms, conditions, limitations and exclusions under this Certificate.

Upon completion of the preadmission or emergency admission review, Blue Cross and Blue Shield will send you a letter confirming that you or your representative called Blue Cross and Blue Shield. A letter authorizing a length of service or length of stay will be sent to you, your Physician, Behavioral Health Practitioner and/or the Hospital or facility.

An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care service is Medically Necessary. If the extension is determined not to be Medically Necessary, the coverage for the length of stay/service will not be extended, except as otherwise described in the ***Complaint/Appeal Procedure*** section under this Certificate.

A length of stay/service review, also known as a concurrent Medical Necessity review, is when 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 Urgent Care or an ongoing course of treatment, the Plan will make a determination on the request/appeal as soon as possible 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).

PREDETERMINATION REVIEW

Predetermination is an optional Medical Necessity review by the Plan of a medical procedure, treatment or test, that has been recommended by your Physician in order to determine if it meets approved Blue Cross and Blue Shield medical policy guidelines. A Predetermination review is not the same as Prior Authorization. Prior Authorization

is a required process for the Provider to get approval from the Plan before you are admitted to the Hospital for certain types of Covered Services. A Predetermination review can help you avoid unexpected out-of-pocket costs by determining ahead of time if a recommended service will be covered by your health care plan. If a service requires Prior Authorization, a Predetermination is not available.

A Predetermination is not a guarantee of Benefits. Actual availability of Benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions under this Certificate. Please coordinate with your Provider to submit a written request for Predetermination.

Below are some examples (not an exhaustive list) of some common services for which a Predetermination review is recommended:

- Certain higher cost Durable Medical Equipment;
- Surgeries that might be considered cosmetic; and
- Services and supplies that may be Experimental/Investigational under certain circumstances.

General Provisions Applicable to All Predeterminations

1. No Guarantee of Payment

A Predetermination is not a guarantee of Benefits or payment of Benefits by the Plan. Actual availability of Benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Plan. Even if the service has been approved on Predetermination, coverage or payment can be affected for a variety of reasons. For example, the Member may have become ineligible as of the date of service or the Member's Benefits may have changed as of the date of service.

2. Request for Additional Information

The Predetermination process may require additional documentation from the Member's health care Provider or pharmacist. In addition to the written request for Predetermination, the health care Provider or pharmacist may be required to include pertinent documentation explaining the proposed services, the functional aspects of the treatment, the projected outcome, treatment plan and any other supporting documentation, study models, prescription, itemized repair and replacement cost statements, photographs, x-rays, etc., as may be requested by the Plan to make a determination of coverage pursuant to the terms and conditions of this Plan.

POST-SERVICE MEDICAL NECESSITY REVIEW

A Post-Service Medical Necessity Review, sometimes referred to as a retrospective review or post-service claims request, is the process of determining coverage after treatment has been provided and is based on Medical Necessity guidelines. A Post-Service Medical Necessity Review confirms Member eligibility, availability of Benefits at the time of service, and reviews necessary clinical documentation to ensure service was Medically Necessary. Providers should submit appropriate documentation at the time of a Post-Service Medical Necessity Review request. A Post-Service Medical Necessity Review may be available when Prior Authorization or Predetermination was not obtained prior to services being rendered.

GENERAL PROVISIONS APPLICABLE TO ALL POST-SERVICE MEDICAL NECESSITY REVIEWS

1. No Guarantee of Payment

A Post-Service Medical Necessity Review is not a guarantee of Benefits. Actual availability of Benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Certificate. Post-Service Medical Necessity Review does not guarantee payment of Benefits by the Plan, for instance a Member may become ineligible as of the date of service or the Member's Benefits may have changed as of the date of service.

2. Request for Additional Information

The Post-Service Medical Necessity Review process may require additional documentation from the Member's health care Provider or pharmacist. In addition to the written request for Post-Service Medical Necessity Review, the health care Provider or pharmacist may be required to include pertinent documentation explaining the services rendered, the functional aspects of the treatment, the projected outcome, treatment plan and any other supporting documentation, study models, prescription, itemized repair and replacement cost statements, photographs, x-rays, etc., as may be requested by the Plan to make a determination of coverage pursuant to the terms and conditions of this Certificate.

ALLOWABLE CHARGE

To take full advantage of the negotiated pricing arrangements in effect between the Plan 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 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 Coinsurance amounts which may be applicable to your Covered Services. We will then determine your Benefits under this Certificate and direct any payment to your Network Provider.

REMEMBER …
You receive the maximum Benefits allowed whenever you utilize the services of an Oklahoma 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 60% of the base Medicare reimbursement rate. However, in no event will the reimbursement exceed 90% of the lowest amount the Plan would have paid a Network Provider for the same services.

  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 90% of the average contract rate. Blue Cross and Blue Shield of Oklahoma 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 Deductible, Copayment and/or Coinsurance amounts. This difference may be considerable. To find out an estimate of the Plan's Non-Contracting Allowable Charge for a particular service, you may call the Customer Service number shown on the back of your Identification Card.

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

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

CONTINUITY OF CARE

If you are under the care of a Network Provider who stops participating in the Plan's network, (for reasons other than failure to meet applicable quality standards, including medical incompetence or professional behavior, or fraud), you may be able to continue coverage for that Provider's Covered Services, at the in-network Benefit level if one of the following conditions is met:

You are undergoing a course of treatment for a serious and complex condition, you are undergoing institutional or inpatient care, you are scheduled to undergo nonelective surgery from the Provider (including receipt of postoperative care from such Provider with respect to such surgery), you are pregnant or undergoing a course of treatment for the pregnancy, or you are determined to be terminally ill. A serious and complex condition is one that (1) for an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm care (for example, you are currently receiving chemotherapy, radiation therapy, or post-operative visits for a serious acute disease or condition), and (2) for a chronic illness or condition, is (i) life-

threatening, degenerative, disabling or potentially disabling, or congenital, and (ii) requires specialized medical care over a prolonged period of time.

Continuity coverage described in this provision shall continue until the treatment is complete, but will not extend for more than 90 days beyond the date the Provider's termination takes effect. If you are in the second or third trimester of pregnancy when the Provider's termination takes effect, coverage may be extended through delivery and postpartum.

You have the right to appeal any decision made for a request for Benefits under this provision, as explained in the ***Complaint/Appeal Procedure*** section of this Certificate.

AMENDMENTS

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

Because of changes in federal or state laws, or changes in your coverage, or the special needs of your Group, provisions called amendments may be added to your Certificate.

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

IDENTIFICATION CARD

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

Your Identification Card shows the 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 covered member of your family.

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

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

DESIGNATING AN AUTHORIZED REPRESENTATIVE

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

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

QUESTIONS

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

Or, you can write to:

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

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

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

Eligibility, Enrollment, Changes & Termination

This section tells:

- How and when you become eligible for coverage;
- 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; and
- What rights you have when your coverage stops.

WHO IS AN ELIGIBLE PERSON

Unless otherwise specified in the Group Contract, the Benefits described in this Certificate will be provided to persons who:

- Meet the definition of an Eligible Person as specified by the Group Contract;
- Have applied for this coverage and received an eligibility determination from the Group and/or the Plan;
- Reside, live or work in the geographic area ("Network Service Area") designated by the Plan;
- Have received a Blue Cross and Blue Shield of Oklahoma Identification Card.

You may contact the Customer Service Department at the number shown on your Identification Card to determine if you are in the Network Service Area or access the Web site at www.bcbsok.com.

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

WHO IS AN ELIGIBLE DEPENDENT

An Eligible Dependent is defined as:

- your spouse or Domestic Partner. NOTE: Domestic Partner coverage is available at your Group's discretion. Contact your Group Administrator for information on whether Domestic Partner coverage is available for your Group.
- your Dependent child. Wherever used in this Certificate, "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, your spouse or your Domestic Partner (provided your Group covers Domestic Partners) is a party in a legal action in which the adoption of the child is sought), under 26 years of age, regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status, eligibility for other coverage, or any combination of those factors. A child not listed above who is legally and financially dependent upon the Member or his/her spouse or Domestic Partner is also considered a Dependent child under the Group Health Plan, provided proof of dependency is provided to the Plan, as appropriate.

  A Dependent child who is medically certified as disabled and dependent upon the Member or his/her spouse or Domestic Partner (provided the Group covers Domestic Partners) 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, dependency, and/or disability status upon initial enrollment and from time to time thereafter as the Plan may require.

If two Eligible Persons are married to each other, or in a Domestic Partnership (provided the Group covers Domestic Partners), one may enroll as a Member and the other as a Dependent, or both may enroll as Members. Their child or children may be covered as Dependents under either person's coverage, but not under both.

APPLYING FOR COVERAGE

You may apply for coverage in a Group Health Plan 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 Certificate 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 Group Health Plans for yourself and/or your Dependents during one of the following enrollment periods.

INITIAL AND ANNUAL OPEN ENROLLMENT PERIODS/EFFECTIVE DATE OF COVERAGE

Your Group will designate initial and annual open enrollment periods during which you may apply for or change coverage in a Group Health Plan for yourself and/or your Dependents. Your and/or your Dependents' Effective Date will be assigned by the Plan, according to the provisions of the Contract in effect for your Group.

If your Group has a waiting period prior to the Effective Date of your coverage, such waiting period may not exceed 90 days, unless permitted by applicable law. If our records show that your Group has a waiting period that exceeds the time period permitted by applicable law, then we reserve the right to begin your coverage on a date that we believe is within the required period. Regardless of whether we exercise that right, your Group is responsible for your waiting period. If you have questions about your waiting period, please contact your Group Administrator.

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

SPECIAL ENROLLMENT PERIODS/EFFECTIVE DATE OF COVERAGE

Your Group Health Plan includes special enrollment periods during which individuals who previously declined coverage are allowed to enroll in or change coverage in a Group Health Plan for yourself and/or your Dependents.

You must provide acceptable proof of a special enrollment event. *"Special Enrollment Events"* are described in detail below. The Plan will review this proof to verify your eligibility for special enrollment. Failure to provide acceptable proof of a special enrollment event will delay or prevent enrollment under this Certificate. Please call the Customer Service number shown on your Identification Card for additional information.

- **Special Enrollment Events**

  You must apply for coverage within 31 days from the date of any of the following Special Enrollment Events:

  - You gain a Dependent or become a Dependent through marriage or the establishment of a Domestic Partnership (provided your Group covers Domestic Partners). New coverage for you and/or your Dependents will be effective on the date determined by the Plan.
  - 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 on the date of birth, adoption, or Placement for Adoption.

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

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

- You gain access to a new Group Health Plan as a result of a permanent move.
- You and/or your Dependents experience a loss of other coverage and you meet the following requirements:
    - You and/or your Dependent must otherwise be eligible for coverage under the terms of the Group Health Plan.
    - When coverage under this Group Health Plan was previously declined, you and/or your Dependent must have been covered under another Group Health Plan or must have had other health insurance coverage.
    - When the coverage was previously declined:
        - you and/or your Dependent had COBRA Continuation Coverage under another plan and COBRA Continuation under that other plan has since been exhausted; or
        - if the other coverage that applied to you and/or your Dependent when enrollment was declined was not under a COBRA continuation provision, either the other coverage has been terminated as a result of loss of eligibility for the coverage or employer contributions towards the other coverage have been terminated.

          For purposes of the above provision, "exhaustion of COBRA Continuation Coverage" means that the individual's COBRA Continuation Coverage has ceased for any reason other than failure to pay premiums on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of material fact in connection with the plan).

          "Loss of eligibility for coverage" includes a loss of coverage as a result of any of the following:

        - Legal separation, divorce, death, or dissolution of a Domestic Partnership (if applicable);
        - Loss of Dependent status, such as attaining the limiting age to be eligible as a Dependent child under this Certificate;
        - 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;
        - 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; or
        - You incur a claim that would meet or exceed a lifetime limit on all Benefits.

        - 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 material fact in connection with the plan).
    - Your application for special enrollment must be received by the Plan within 31 days following the loss of other coverage.

Coverage under special enrollment will be effective no later than the first day of the month after the Plan receives your application for enrollment for yourself or on behalf of your Dependent(s).

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

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

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

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

  - The Employee's or Dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility; or
  - The Employee or Dependent becomes eligible for a Group Health Plan premium assistance subsidy under Medicaid or CHIP.

    An Employee must request this special enrollment into the Group Health Plan within 60 days of the loss of Medicaid or CHIP coverage, and within 60 days of the Employee or Dependent becoming eligible for a Group Health Plan premium assistance subsidy under Medicaid or CHIP.

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.

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

NOTIFICATION OF ELIGIBILITY CHANGES

It is the Subscriber's responsibility to notify the Plan, 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 visit our Web site at www.bcbsok.com.

QUALIFIED COURT ORDERS FOR MEDICAL COVERAGE FOR DEPENDENT CHILDREN

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

The order must include specific information such as:

- your name and address;

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

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

The Plan has to follow certain procedures with respect to qualified medical child support orders. If such an order is issued concerning your child, you should contact a Customer Service Representative at the number shown on your Identification Card.

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.

COBRA CONTINUATION COVERAGE

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

- **Eligibility for Continuation Coverage**

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

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

  – your divorce or legal separation; or
  – your Dependent child ceasing to be an Eligible Dependent under the Plan; or
  – the birth, adoption or Placement for Adoption of a child while you are covered under COBRA Continuation Coverage.

  A Domestic Partner is not recognized as a spouse for certain federally regulated programs, such as COBRA Continuation Coverage and Medicare.

- **Election of Continuation Coverage**

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

  - the date the Qualifying Event would cause you or your Dependent to lose coverage; or
  - the date your Employer notifies you, or your Eligible Dependent, of your COBRA Continuation Coverage rights.

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

- **COBRA Continuation Coverage Period**

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

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

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

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

    o the ineligibility of a Dependent child;

    provided the premiums are paid for the coverage as required.

- **Disability Extension**

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

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

- **Multiple Qualifying Events**

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

- **Special TAA/ATAA Election Period**

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

WHEN COVERAGE UNDER THIS CERTIFICATE ENDS

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

- In the case of an Employee whose coverage is terminated under a Group Health Plan that is not subject to COBRA Continuation Coverage, such Employee and his/her Dependents shall remain insured under the Contract for a period of 63 days after such termination, unless during such period the Employee and his/her Dependents shall otherwise become entitled to similar insurance from some other source.
- When a Subscriber ceases to be an Eligible Dependent by reason of death, coverage for that Subscriber will cease on the date of death.
- A Subscriber's COBRA Continuation Coverage, when applicable, will cease on the earliest to occur of the following dates:
  - the date the billing period ends following expiration of the 18-month, 29-month or 36-month COBRA Continuation Coverage period, whichever is applicable;
  - the first day of the month that begins more than 30 days after the date of the Social Security Administration's final determination that the Subscriber is no longer disabled (when coverage has been extended from 18 months to 29 months due to disability);
  - the date on which the Group stops providing any Group Health Plan to any Employee;
  - the date on which coverage stops because of a Subscriber's failure to pay to the Group any premiums required for the COBRA Continuation Coverage;
  - the date on which the Subscriber first becomes (after the date of the election) covered under any other Group Health Plan which does not contain any exclusion or limitation with respect to a preexisting condition applicable to the Subscriber (or the date the Subscriber has satisfied the preexisting condition exclusion period under that plan); or
  - the date on which the Subscriber becomes (after the date of the election) entitled to benefits under Medicare.

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

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

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

WHAT WE WILL PAY FOR AFTER YOUR COVERAGE ENDS

- If your coverage terminates for any reason under a Group Health Plan that is not subject to COBRA Continuation Coverage, Benefits under this Certificate will end on the effective date and time of such termination. However, termination will not deprive you of any Benefits to which you would otherwise be entitled for Covered Services incurred during the course of a Hospital confinement that began before the date and time of termination. Benefits will be provided only for a period of time which is the lesser of:
  - a period of time equal to the length of time you were covered under this Certificate; or
  - the duration of the Hospital confinement; or
  - 90 days following termination of coverage; or
  - the date you become entitled to similar insurance through some other source.
- If your coverage ends because the Member terminates employment, or because the Group itself is terminated, Benefits under this Certificate will end on the effective date and time your coverage is terminated, except as provided below:
  - In the event the Group Health Plan is not subject to COBRA Continuation Coverage, a Subscriber who was insured under this Certificate for six months prior to the date coverage is terminated will be entitled to an

extension of Benefits under this Certificate if:

- Covered Services are incurred due to illness or injury because of which the Subscriber is Totally Disabled at the date and time such coverage is terminated; or
- the Subscriber has not completed a plan of surgical treatment (including maternity care and delivery expenses) which began prior to the date and time of such termination of coverage.

– Coverage for the extension of Benefits shall be limited to a period which is the lesser of:

- the duration of the uninterrupted existence of such Total Disability or completion of a plan of surgical treatment; or
- the payment of maximum Benefits; or
- six months following the date and time of termination of coverage.

- Your premiums must be submitted to the Plan during the period of the extension of Benefits and will be the same premiums which would have been charged for the coverage provided under this Certificate had termination not occurred.
- The Plan shall have no liability for any Benefits for Covered Services incurred after the termination of this Certificate, except as provided above.
- Benefits are not provided, even if Prior Authorization was received from the Plan, after a Subscriber's coverage under this Certificate is terminated.

TRANSFERS OUT OF THE NETWORK SERVICE AREA

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

WHEN YOU TURN AGE 65

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

Your coverage may include:

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

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

WHEN YOU RETIRE

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

When you become age 65, you may apply for one of our Medicare Supplement Policies. Check with your Group Administrator for more information.

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

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

Comprehensive Health Care Services

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

Certain services are covered pursuant to Blue Cross and Blue Shield of Oklahoma medical policies and clinical procedure and coding policies, which are updated throughout the plan year. The medical policies are guides considered by Blue Cross and Blue Shield of Oklahoma when making coverage determinations and lay out the procedure and criteria to determine whether a procedure, treatment, facility, equipment, drug or device is Medically Necessary and is eligible as a Covered Service or is Experimental/Investigational, cosmetic, or a convenience item. The clinical procedure and coding policies provide information about what services are reimbursable under the Benefit plan. The most up-to-date medical and clinical procedure and coding policies are available at www.bcbsok.com, or call Customer Service at the number listed on the back of your insurance card.

Please note: All Inpatient services and many Outpatient services listed in this section are subject to the *"Prior Authorization"* requirements set forth in the *Important Information* section of this Certificate. If you fail to comply with these requirements, Benefits for Covered Services may be reduced or denied.

PREVENTIVE CARE SERVICES

Any of the following Covered Services performed by a Provider.

Preventive Care Services received from Network or BlueCard Providers are not subject to Deductible, Copayment, Coinsurance and/or dollar maximum. 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. In addition, Benefits are provided for the purchase of manual or electric grade breast pumps or the rental of hospital grade pumps. The rental term for hospital grade breast pumps is up to purchase price of $1,000 or 12 months (whichever comes first) per Benefit Period. Benefits for electric grade breast pumps are limited to one per Benefit Period.
    - 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 (including, but not limited to, 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 Drugs and Related Services*** section of your Certificate, *if applicable*.

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 Drug List. To determine if a specific drug is on the Contraceptive Drug List, you may access the Web site at www.bcbsok.com or contact Customer Service at the toll-free number on your Identification Card.

Drugs (including both prescription and over-the-counter) that fall within a category of the current "A" or "B" recommendations of the United States Preventive Services Task Force and that are listed on the ACA Preventive Services Drug List (to be implemented in the quantities and within the time period allowed under applicable law) will be covered and will not be subject to any Deductible, Copayment, Coinsurance or dollar maximum when obtained from a Participating Pharmacy. Drugs on the Preventive Services Drug List that are obtained from a non-Participating Pharmacy, may be subject to Deductible, Copayment, Coinsurance, or dollar maximums, if applicable.

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

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

Preventive Care Services will be implemented in the quantities and within the time periods allowed under applicable law. 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 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 health 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, annual routine obstetrical/gynecological examinations, annual In Home Health Assessment, bone density tests; and screening for prostate cancer and colorectal cancer; (2) tobacco use counseling and interventions (including a screening for tobacco use, counseling and FDA-approved tobacco cessation medications); and (3) healthy diet counseling and obesity screening/counseling.

NOTE: Tobacco cessation medications are covered under the ***Outpatient Prescription Drugs and Related Services*** section of this Certificate when prescribed by a Network Provider.

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 listed above ***may*** be subject to any Deductibles, Copayments**,** Coinsurance and/or Benefit 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 Certificate (for example: *"Hospital Services"*, *"Surgical/Medical Services"*, *"Outpatient Diagnostic Services"* or ***Outpatient Prescription Drugs and Related Services***).

EMERGENCY CARE SERVICES

Services provided in a Hospital emergency department (emergency room) or other comparable facility 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 (or, with respect to a pregnant woman, the health of the woman or her unborn child);
- serious impairment to bodily function; or
- serious dysfunction of any bodily organ or part; or
- with respect to a pregnant woman who is having contractions:
  - there is inadequate time to effect a safe transfer to another Hospital before delivery; or
  - transfer may pose a threat to the health or safety of the woman or the unborn child.

Services provided in an emergency room that are not Emergency Care may be excluded from emergency coverage, although these services may be covered under *"Surgical/Medical Services"*, if applicable. Non-emergency services provided in an emergency room for treatment of Mental Health and Substance Use Disorder will be paid the same as Emergency Care services.

Coverage for Emergency Care shall be provided in accordance with the terms and conditions of the appropriate Benefit section of this Certificate (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 allowance is equal to the most prevalent semiprivate room charges of your Hospital). Private room charges in excess of the semiprivate room allowance will not be eligible for Benefits unless the patient is required under the infection control policy of the Hospital to be in isolation to prevent contagion;

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

Inpatient services are subject to the *"Prior Authorization"* requirements of this Certificate (see *Important Information* section). 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.

Outpatient Surgery performed at an Out-of-Network Hospital is subject to the *"Prior Authorization"* requirements of this Certificate (see *Important Information* section).

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

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[1] 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 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 Health and Substance Use Disorder, except as specified.

  - Inpatient Medical Care Visits

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

  - Intensive Medical Care

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

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

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

  - Newborn Well Baby Care

    Routine Nursery Care visits to examine a newborn 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.

[1] *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.*

- **Outpatient Medical Services**

  Outpatient Medical Care that is not related to Surgery, pregnancy or Mental Health and Substance Use Disorder, 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.

  - Virtual Visits

    Covered Services provided via consultation with a licensed Provider through interactive video, or other communication technology allowed by applicable law, via online portal or mobile application. Virtual Visits provide access to Providers who can provide diagnosis and treatment of non-emergency medical and Mental Health and Substance Use Disorder conditions in situations that may be handled without a traditional office visit, Urgent Care visit or Emergency Care visit.

  - Contraceptive Devices Contraceptive devices which are:

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

  - Audiological Services

    Audiological services and hearing aids, limited to:

    - **One hearing aid per ear every 48 months; and**
    - **Up to four additional ear molds per Benefit Period if Medically Necessary.**

    Hearing aids must be prescribed, filled and dispensed by a licensed audiologist or other Provider acting within the scope of their license.

OUTPATIENT DIAGNOSTIC SERVICES

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

OUTPATIENT THERAPY SERVICES

- Radiation Therapy
- Chemotherapy

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

- Respiratory Therapy
- Dialysis Treatment

Dialysis Treatment performed by an Out-of-Network Provider is subject to the *"Prior Authorization"* requirements of this Certificate (see *Important Information* section).

- Infusion Therapy

  Some Outpatient Infusion Therapy services for routine maintenance drugs may be identified as capable of being safely administered outside of an outpatient Hospital setting. A Subscriber's out-of-pocket expenses may be lower when services are provided by a Physician in an Infusion Suite, a home or an office, instead of a Hospital. Non-maintenance outpatient Infusion Therapy services will be covered the same as any other illness. The *Schedule of Benefits for Comprehensive Health Care Services* describes payment for Outpatient Infusion Therapy services.

- 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* in the front of this Certificate. This visit limit is not applicable to Therapy Services for treatment of autism and autism spectrum disorder.

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 mother's life 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 Certificate after childbirth, except as otherwise provided in this section; or
  - A minimum of 96 hours of Inpatient care at a Hospital following a delivery by cesarean section for the mother and newborn infant who are covered under this Certificate after childbirth, except as otherwise provided in this section; and
  - Postpartum home care following a vaginal delivery if childbirth occurs at home or in a birthing center licensed as a birthing center. The coverage shall provide for one home visit within 48 hours of childbirth by a licensed health care Provider whose scope of practice includes providing postpartum care. The visits shall include, at a minimum:
    - physical assessment of the mother and newborn infant;
    - parent education regarding childhood immunizations;
    - training or assistance with breast or bottle feeding; and
    - performance of any Medically Necessary and appropriate clinical tests.

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

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

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

MASTECTOMY AND RECONSTRUCTIVE SURGICAL SERVICES

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

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

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

Breast reconstruction or implantation or removal of breast prostheses is a Covered Service only when 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 Prior Authorization and must be performed in and by a Provider that meets the criteria established by the Plan for assessing and selecting Providers for transplants.

Prior Authorization 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 Prior Authorization is obtained. Failure to obtain Prior Authorization for Inpatient services may result in a $500 Benefit reduction, or denial of Benefits, as set forth in the *"Prior Authorization"* requirements of this Certificate (see *Important Information* section). The Plan has the sole and final authority for approving or declining requests for Prior Authorization.

- **Definitions**

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

  – **Bone Marrow Transplant**

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

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

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

  – **High-Dose Chemotherapy**

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

  – **High-Dose Radiation Therapy**

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

  – **Prior Authorization**

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

- **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 this Certificate, Benefits will be provided for Covered Services rendered by a Hospital, Physician, or other Provider for the human organ and tissue transplant procedures set forth below.

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

- **Exclusions and Limitations Applicable to Organ/Tissue/Bone Marrow Transplants**

  - The transplant must meet the criteria established by the Plan for assessing and performing organ or tissue transplants, or Bone Marrow Transplant procedures, as set forth in the Plan's written medical policies.
  - In addition to the ***Exclusions*** set forth elsewhere in this Certificate, no Benefits will be provided for the following organ or tissue transplants or Bone Marrow Transplants or related services:
    - Adrenal to brain transplants.
    - Allogeneic islet cell transplants.
    - High-Dose Chemotherapy or High-Dose Radiation Therapy if the associated autologous or allogeneic Bone Marrow Transplant, stem cell or progenitor cell treatment or rescue is not a Covered Service.
    - Small bowel transplants using a living donor.
    - Any organ or tissue transplant or Bone Marrow Transplant from a non-human donor or for the use of non-human organs for extracorporeal support and/or maintenance.
    - Any artificial device for transplantation/implantation, except in limited instances as reflected in the Plan's written medical policies.
    - Any organ or tissue transplant or Bone Marrow Transplant procedure which the Plan considers to be Experimental, Investigational and/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 Certificate.

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

- **Donor Benefits**

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

  – When both the recipient and the living donor are Subscribers, each is entitled to the Benefits of this Certificate.

  – When only the recipient is a Subscriber, both the donor and the recipient are entitled to the Benefits of this Certificate. 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 this Certificate.

  – When only the living donor is a Subscriber, the donor is entitled to the Benefits of this Certificate. 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 this Certificate as Experimental, Investigational and/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;

  – 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 this Certificate.

AMBULATORY SURGICAL FACILITY SERVICES

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

- Such services are Medically Necessary;

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

Outpatient Surgery performed at an Out-of-Network Ambulatory Surgical Facility is subject to the *"Prior Authorization"* requirements of this Certificate (see *Important Information* section).

SERVICES RELATED TO TREATMENT OF AUTISM AND AUTISM SPECTRUM DISORDERS

Covered Services which are Medically Necessary for the screening, diagnosis and treatment of Autism Spectrum Disorder, provided the Subscriber continually and consistently shows sufficient progress and improvement as determined by the health care Provider.

Treatment of Autism Spectrum Disorder consists of evidence-based care and related equipment prescribed or ordered for an individual diagnosed with an Autism Spectrum Disorder by a licensed Physician or a licensed doctoral-level psychologist who determines the care to be Medically Necessary, including, but not limited to:

- Behavioral health counseling and treatment programs, including Applied Behavior Analysis, that are:
  - necessary to develop, maintain or restore, to the maximum extent practicable, the functioning of an individual; and
  - provided or supervised by a board-certified behavior analyst, a board-certified assistant behavior analyst or by a licensed doctoral-level psychologist so long as the services performed are commensurate with the psychologist's university training and experience.

  Applied Behavior Analysis is subject to the "Prior Authorization" requirements set forth in the *Important Information* section of this Certificate. If you fail to comply with these requirements, Benefits for Covered Services may be reduced or denied.
- Medications prescribed by a licensed Physician and any health-related services deemed Medically Necessary to determine the need or effectiveness of the medications.
- Direct or consultative services provided by a psychiatrist or psychologist licensed in the state in which the psychiatrist or psychologist practices.
- Therapeutic care services provided by licensed or certified speech therapists, occupational therapists or physical therapists. Speech Therapy, Physical Therapy and Occupational Therapy visits related to treatment of Autism Spectrum Disorder are not subject to the limitations specified under "Outpatient Therapy Services".

Except for Inpatient services, if a Subscriber is receiving treatment for an Autism Spectrum Disorder, the Plan, shall have the right to review the treatment plan annually, unless the Plan and the Subscriber's treating Physician or psychologist agree that a more frequent review is necessary. Any such agreement regarding the right to review a treatment plan more frequently shall apply only to the particular Subscriber being treated for an Autism Spectrum Disorder and shall not apply to all individuals being treated for Autism Spectrum Disorder by a Physician or psychologist. The cost of obtaining any review or treatment plan shall be borne by the Plan.

PSYCHIATRIC CARE SERVICES

All Inpatient services and certain Outpatient services are subject to the *"Prior Authorization"* requirements set forth in the *Important Information* section of this Certificate. If you fail to comply with these requirements, Benefits for Covered Services may be reduced or denied.

We pay the scheduled amounts for the following Covered Services you receive from a Provider to treat Mental Health and Substance Use Disorder:

- Inpatient Facility Services

  Covered Inpatient Hospital Services provided by a Hospital, Psychiatric Hospital, Residential Treatment Center

or other Plan-approved Provider (including partial hospitalization programs).

- Inpatient Medical Services

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

  - Medical Care visits, **limited to one visit or other service per day**;
  - Individual Psychotherapy;
  - Group Psychotherapy;
  - Psychological Testing; and
  - Convulsive Therapy Treatment.

    Electroshock treatment or convulsive drug therapy including anesthesia when 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

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

AMBULANCE SERVICES

- Medically Necessary transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured:
  - From your home to a Hospital;
  - From the scene of an accident or medical emergency to a Hospital;
  - Between Hospitals;
  - Between a Hospital and a Skilled Nursing Facility; or
  - From the Hospital to your home.
- Ambulance Services means local transportation to the ***closest facility*** appropriately equipped and staffed for treatment of the Subscriber's condition. If none, you are covered for trips to the closest such facility outside your local area.
- Ambulance Services for non-Emergency Care may be covered when, in addition to the above requirements, the Subscriber's condition is such that any other form of transportation would be medically contraindicated.
- Air ambulance services are covered only when:
  - Air ambulance services are Medically Necessary; and
  - Terrain, distance, your physical condition or other circumstances require the use of air ambulance services rather than ground ambulance services.

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 Certificate.

Private Duty Nursing Services are subject to the *"Prior Authorization"* requirements of this Certificate (see *Important Information* section).

REHABILITATION CARE/HABILITATION 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.

Benefits for Rehabilitation Care/Habilitation Care are limited to the number of visits specified in the *Schedule of Benefits for Comprehensive Health Care Services* in the front of this Certificate.

Rehabilitation Care and Habilitation Care are subject to the *"Prior Authorization"* requirements of this Certificate (see *Important Information* section). Failure to comply with these requirements will result in a $500 reduction in Benefits for Inpatient Rehabilitation Care/Habilitation Care if, upon receipt of a claim, Benefits are available under this Certificate.

SKILLED NURSING FACILITY SERVICES

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

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

Skilled Nursing Facility Services are subject to the *"Prior Authorization"* requirements of this Certificate (see *Important Information* section). 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 Certificate.

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 a Plan-approved Provider and the care is prescribed by a Physician:

- Medical and surgical supplies;
- Prescribed drugs;
- Oxygen and its administration.

Benefits for Home Health Care Services are limited to the number of visits specified in the *Schedule of Benefits for Comprehensive Health Care Services* in the front of this Certificate. Benefits are limited to the following:

- Professional services of an RN, LPN or LVN;
- Medical social service consultations;
- Health aide services while you are receiving covered nursing or Therapy Services;
- Services of a licensed registered dietitian 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 Services are subject to the *"Prior Authorization"* requirements of this Certificate (see *Important Information* section).

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;
- Food or home-delivered meals;
- Infusion Therapy, except when you have received Prior Authorization from the Plan for these services.

HOSPICE SERVICES

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

Hospital Hospice Services are subject to the *"Prior Authorization"* requirements of this Certificate (see *Important Information* section). 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 Certificate.

DENTAL SERVICES FOR ACCIDENTAL INJURY

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

DIABETES EQUIPMENT, SUPPLIES AND SELF-MANAGEMENT SERVICES

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

frequent hospitalizations and complications. Diabetes self-management training must be conducted in accordance with the standards developed by the Oklahoma State Board of Health in consultation with a national diabetes association affiliated with this state and at least three medical directors of health benefit plans selected by the Oklahoma State Department of Health. Coverage for diabetes self-management training, including medical nutrition therapy relating to diet, caloric intake and diabetes management (excluding programs of which the only purpose 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 dietitian or licensed certified nutritionist when authorized by the patient's supervising Physician and when Medically Necessary.

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

SERVICES RELATED TO CLINICAL TRIALS

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

- 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.

For purposes of this provision, "Routine Patient Costs" generally include all items and services consistent with the coverage provided under this Certificate 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 investigational item, device or service, itself;
- Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

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 Certificate. Eyeglass lens, soft lens and contact lens are included if prescribed as part of postoperative treatment for cataract extraction. Implantation or removal of breast prostheses is a Covered Service only in connection with reconstructive breast Surgery performed solely and directly as a result of mastectomy which is Medically Necessary.

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

ORTHOTIC DEVICES

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

Benefits will be provided for the following orthotic devices:

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

The following devices are not covered, except as specified under *"Diabetes Equipment, Supplies and Self-Management Services"*:

- Arch supports and other foot support devices;
- Elastic/compression 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 Certificate.

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 for wigs or other scalp prostheses are limited to the maximum amount specified in the *Schedule of Benefits for Comprehensive Health Care Services* in the front of this Certificate.

Outpatient Prescription Drugs and Related Services

Subject to the ***Exclusions,*** conditions and limitations of this Certificate, a Subscriber is entitled to the Benefits of this section for covered Outpatient Prescription Drugs and related services. Benefits are subject to the Deductible, and/or 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).
- Oral Chemotherapy when prescribed by a licensed Physician. Your Deductible, Copayment or Coinsurance amount will not apply to orally administered anticancer medications when received from a Participating Pharmacy. Coverage of prescribed orally administered anticancer medications when received from a non-preferred specialty Pharmacy Provider or non-Participating Pharmacy Provider 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-injectable and other 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 should be purchased from a Participating Specialty Pharmacy.
- Specialty Pharmacy Drugs (should be purchased from a Participating Specialty Pharmacy in order to receive the highest level of Benefits).
- Select vaccinations (when administered by a Participating Retail Pharmacy Vaccination Network Provider). For a current listing of vaccines available through this coverage, call Customer Service at the number listed on your Identification Card or visit the Plan's Web site at https://www.bcbsok.com/member/prescription-drug-plan-information/drug-lists. NOTE: Select vaccinations administered through a Participating Retail Pharmacy Vaccination Network Provider are not subject to the Deductible, Copayment and/or Coinsurance provisions of this Certificate.
- Drugs prescribed by a Physician or other Provider as part of *"Preventive Care Services"* as defined in this Certificate.

  In order to be a Covered Drug under this ***Outpatient Prescription Drugs 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, most Generic Drugs are categorized as Tier 1 or Tier 2 drugs, while Specialty Drugs may be classified as Tier 5 or Tier 6 drugs (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.

- Tier 1 – includes mostly Preferred Generic Drugs and may contain some Brand Name Drugs.
- Tier 2 – includes mostly Non-Preferred Generic Drugs and may contain some Brand Name Drugs.
- Tier 3 – includes mostly Preferred Brand Name Drugs and may contain some Generic Drugs.
- Tier 4 – includes mostly Non-Preferred Brand Name Drugs and may contain some Generic Drugs.
- Tier 5 – includes mostly Preferred Specialty Drugs and may contain some Generic Drugs.
- Tier 6 – includes mostly Non-Preferred Specialty Drugs and may contain some Generic Drugs.

Drugs listed on the Drug List are selected by the Plan based upon the recommendations of a committee, which is made up of current and previously practicing Physicians and pharmacists from across the country, some of whom are employed by or affiliated with the Plan. The committee considers existing drugs approved by the FDA, as well as those newly FDA-approved for inclusion on the Drug List. Entire drug classes are also regularly reviewed. Some of the factors committee members evaluate include each drug's safety, effectiveness, cost and how it compares with drugs currently on the Drug List.

Positive changes (e.g., adding drugs to the Drug List, drugs moving to a lower payment tier) occur quarterly after review by the committee. Changes to the Drug List that could have an adverse financial impact to you (e.g., drug exclusion, drug moving to a higher payment tier, or drugs requiring step therapy or Prior Authorization) occur quarterly or annually. However, when there has been a pharmaceutical manufacturer's recall or other safety concern, changes to the Drug List may occur more frequently.

The Drug List and any modifications will be made available to you. By accessing the Plan's website at www.bcbsok.com or calling the customer service toll-free number on your Identification Card, you will be able to determine the Drug List that applies to you and whether a particular drug is on the Drug List.

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 Preferred Participating Pharmacy, 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.***

Note: The amount you may pay for a covered insulin drug shall not exceed $30 per 30-day supply or $90 per 90-day supply.

EXTENDED PRESCRIPTION DRUG SUPPLY PROGRAM

Your coverage includes Benefits for up to a 90-day supply of Maintenance Prescription Drugs purchased from a Participating Pharmacy which may only include Preferred Participating retail or Participating Mail-Order 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 more than a 30-day supply of drugs obtained from a Prescription Drug Provider *not* participating in the Extended Prescription Drug Supply Program.

Note: The amount you may pay for a covered insulin drug shall not exceed $30 per 30-day supply or $90 per 90-day supply.

MAIL-ORDER PHARMACY PROGRAM

The Plan has selected a Mail-Order Pharmacy Program to fill and deliver maintenance (long-term) medications.

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 subject to the same limitations and exclusions as the Retail Pharmacy Program. **Items covered through a Specialty Pharmacy are not 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 https://www.bcbsok.com/member/prescription-drug-plan-information/drug-lists, 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 DRUG PROGRAM

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. To receive the highest level of Benefits, Specialty Drugs **should be obtained through an in-network Specialty Pharmacy.**

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.

Specialty Pharmacy Drugs are identified on the Drug List which is available by accessing the Web site at https://www.bcbsok.com/member/prescription-drug-plan-information/drug-lists 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.

- You may not be required to pay the difference in cost between the Allowable Charge of the Brand Name Drug and the Allowable Charge of the Generic Drug if there is a medical reason (e.g., adverse event) you need to take the Brand Name Drug and certain criteria are met. Your health care Provider can submit a request to waive the difference in cost between the Allowable Charge of the Brand Name Drug and Allowable Charge of the Generic Drug. In order for this request to be reviewed, your health care Provider must send in a Med Watch form to the Food and Drug Administration (FDA) to let them know the issues you experienced with the generic equivalent. Your health care Provider must provide a copy of this form when requesting the waiver. The FDA MedWatch form is used to document adverse events, therapeutic inequivalence/failure product quality problems, and product use/medication error. This form is available on the FDA website. If the waiver is granted, applicable Copayment, Coinsurance, and any Deductible will still apply. For additional information, you may access the website at www.bcbsok.com or contact customer service at the toll-free number on your Identification Card.
- If a covered Prescription Drug was paid for using a drug manufacturer's coupon or copayment card, the coupon or copayment card amount will not apply to your Deductible or Out-of-Pocket Limit.

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 drugs.

  – **Extended 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 supply or 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 your Certificate for charges for Prescription Drugs dispensed in excess of the above stated amounts.

  Benefits will not be provided for a prescription refill until 75% of the previous Prescription Order (or 70% for covered prescription eyedrops) has been used by the Subscriber. An exception to this provision may be granted on at least one occasion per year to synchronize your Prescription Drug refills for certain covered maintenance medications so that they are refilled on the same schedule for a given time period. When necessary to permit synchronization, the Plan shall apply a prorated daily cost-sharing rate to any covered medication dispensed by a Participating Pharmacy. Some prescriptions may be subject to a shorter refill window. Please call Customer Service for details.

- **Split-Fill Program**

  If this is your first time using select medications (e.g., oral cancer medications) or you have not filled one of

these medications recently, you may only be able to receive a partial fill (14 – 15-day supply) of the medication for up to the first 3 months of therapy. This is to help see how the medication is working for you. Your cost-share may be adjusted to align with the number of pills dispensed. If the medication is working for you and your Physician wants you to continue on this medication, you may be eligible to receive up to a 30-day supply after completing up to 3 months of the partial supply.

- **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 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 safety or treatment guidelines, Benefits may be subject to a review to determine Medical Necessity, or appropriateness and other restrictions such as limiting coverage to services provided by a certain Provider and/or Pharmacy for the prescribing and dispensing of the controlled substance medication and/or limiting coverage to certain quantities. For the purposes of this provision, controlled substance medications are medications classified and restricted by state or federal laws.

THERAPEUTIC EQUIVALENT RESTRICTIONS

Some equivalent drugs are manufactured under multiple names. In some cases, the Plan may limit Benefits to only one of the equivalents available. If the Subscriber does not accept the therapeutic equivalents that are covered under the Drug List, the drug purchased will not be covered under any Benefit level.

EXCLUSIONS AND LIMITATIONS

In addition to the exclusions and limitations specified in the ***Exclusions*** section of this Certificate, 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 Certificate and/or such coverage is required in accordance with applicable law or regulatory guidance.
- Drugs that are not Medically Necessary or treatment recommendations that are not supported by evidence-based guidelines or clinical practice guidelines.
- Non-FDA approved drugs.
- 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 Certificate.
- 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).
- Pharmaceutical aids such as excipients found in the USP-NF (United States Pharmacopeia-National Formulary)

including, but not limited to, preservatives, solvents, ointment bases, and flavoring, coloring, diluting, emulsifying and suspending agents.

- Administration or injection of any drugs (except for select 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 payable under Part A and Part B of Title XVIII of the Social Security Act (Medicare), or the laws, regulations or established procedures of any county or municipality, except any program which is a state plan for medical assistance (Medicaid), or any Prescription Drug which may be properly obtained without charge under local, state, or federal programs, unless such exclusion is expressly prohibited by law; provided, however, that this exclusion shall not be applicable to any coverage held by you for Prescription Drug expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.
- Any services provided or items furnished for which the Pharmacy normally does not charge.
- 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 Certificate.
- Infertility and fertility medications.
- Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations except those prescribed by a Physician or other Provider as part of the *"Preventive Care Services"* as defined in this Certificate.
- Drugs required by law to be labeled: "Caution — Limited by Federal Law to Investigational Use", or Experimental, Investigational and/or Unproven 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 Certificate. NOTE: This exception does not apply to dietary formula necessary for the treatment of phenylketonuria (PKU) or other heritable diseases.
- Drugs prescribed and dispensed for the treatment of obesity or for use in any program of weight reduction, weight loss or dietary control.
- Drugs the use or intended use of which would be illegal, unethical, imprudent, abusive, not Medically Necessary or otherwise improper.
- Drugs obtained by unauthorized, fraudulent, abusive or improper use of the Identification Card.
- 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 Certificate, 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.
- Compounded medications. For purposes of this exclusion, "compounded medications" are customized medications made by mixing, assembling, packaging or labeling drugs that are not commercially available in a specific dosage form, strength or formulation.
- Replacement of drugs or other items that have been lost, stolen, destroyed or misplaced.
- Shipping, handling or delivery charges.
- Certain drug classes where there are over-the counter alternatives available.
- Institutional packs and drugs which are repackaged by anyone other than the original manufacturer.
- Bulk powders.
- Diagnostic agents, except for diabetic testing supplies or test strips.
- Any self-injectable and other self-administered drugs purchased from a Physician and administered in his/her office.
- Drugs determined by the Plan to have inferior efficacy or significant safety issues.

PRESCRIPTION DRUG PRIOR AUTHORIZATION AND STEP THERAPY PROCESS

The Plan has designated certain drugs which require Prior Authorization in order for Benefits to be available under this Certificate. Prior Authorization means that in order to ensure that a drug is safe, effective, and part of a specific treatment plan, certain medications may require Prior Authorization and the evaluation of additional clinical information before dispensing.

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

You can obtain a listing of the drugs which require Prior Authorization or Step Therapy by contacting a Customer Service Representative at the number shown on your Identification Card. Or, you may request a listing by writing to:

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

Please keep in mind that the listing of drugs requiring Prior Authorization 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 Authorization, you, the Physician or other Provider may request Prior Authorization by calling Customer Service at the number listed on your Identification Card.

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

If the Prior Authorization request is approved your pharmacist will dispense the Prescription Drug as prescribed and collect any applicable Deductible, Copayment and/or Coinsurance amount.

If the Prior Authorization request is 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.

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:

Prime Therapeutics
P.O. Box 25136
Lehigh Valley, PA 18002-5136

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

To view a listing of the drugs which are included in the Prior Authorization /Step Therapy program, please visit our Web site at https://www.bcbsok.com/member/prescription-drug-plan-information/drug-lists. If you have questions about Prior Authorization, or Step Therapy, please call a Customer Service Representative at the number shown on your Identification Card for assistance.

STEP THERAPY EXCEPTION REQUESTS

You or your Provider can ask for a Step Therapy exception. To request this exception, you or your Provider can call the number on the back of your Identification Card or visit our Web site at www.bcbsok.com to ask for a review. The Plan will respond to you and your Provider within 72 hours after the Plan receives your request. If the timeframe for a response ends on a weekend or a legal holiday, the timeframe for the response shall run until the close of the next full business day. If the prescribing Provider indicates that you have a health condition that may jeopardize your life, health or keep you from regaining function, we will respond to such request within 24 hours after the Plan receives your request. If the timeframe for a response ends on a weekend or a legal holiday, the timeframe for the response shall run until the close of the next full business day. If we fail to respond within the required time, the Step Therapy exception request shall be deemed granted. If the request is denied, we will let you and your Provider know why it was denied. If your exception is denied, you may appeal the decision according to the appeals process you will receive with the denial determination. Call the number on the back of your Identification Card if you have any questions.

EXCEPTION REQUESTS

You or your Provider can ask for a Drug List exception if your drug is not on the Drug List. To request this exception, you or your Provider can call the number on the back of your Identification Card to ask for a review. The Plan will let you and your Provider know the coverage decision within 72 hours after they receive your request. If you have a health condition that may jeopardize your life, health or keep you from regaining function, or your current drug therapy uses a non-covered drug, your Provider may be able to ask for an expedited review process by marking the review as an urgent request. The Plan will let you and your Provider know the coverage decision within 24 hours after the Plan receives your request for an expedited review. If the coverage request is denied, we will let you and your Provider know why it was denied and offer you a covered alternative drug (if applicable). If your

exception is denied, the denial determination will include information explaining the appeals process, which includes your right to request review by an Independent Review Organization. Call the number on the back of your Identification Card if you have any questions.

Exclusions

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

WHAT IS NOT COVERED

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

- Which are not prescribed by or performed by or upon the direction of a Physician or other Provider.
- Which the Plan determines are not Medically Necessary, except as specified.
- For any services related to a non-Covered Service. Related services are:
  - services in preparation for the non-Covered Service;
  - services in connection with providing the non-Covered Service;
  - hospitalization required to perform the non-Covered Service; or
  - services that are usually provided following the non-Covered service, such as follow-up care or therapy after Surgery.
- 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 to the extent governmental units provide benefits or would have provided benefits if you had applied for and claimed those 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, supplies or drugs provided to a Subscriber outside the United States, except for Emergency Care.
- 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 or Habilitation Care, 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 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 Certificate.
- 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 or related to the planned delivery of a newborn child at home, or in any setting other than a Hospital, licensed birthing center or other facility licensed to provide such services.
- 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;
  - the improvement of the physiological functioning of a malformed body member resulting from a congenital defect;
  - dental extractions performed in preparation for radiation treatment for neoplasms involving the jaw/mouth; or
  - dental extractions of diseased teeth prior to a solid organ transplant.

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

- For or related to Inpatient treatment of any non-covered dental procedure, except that coverage shall be provided for Hospital Services, Ambulatory Surgical Facility Services, and anesthesia services associated with any Medically Necessary dental procedure when provided to a Subscriber who is severely disabled; or who has a medical or emotional condition which requires hospitalization or general anesthesia for dental care; or who, in the judgment of the treating practitioner, 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 provided for under *"Preventive Care Services"* in the ***Comprehensive Health Care Services*** section of this Certificate or as specified in the ***Pediatric Vision Care Addendum*** attached to this Certificate.
- 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 under "Audiological Services". 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 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 dysfunction 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; bariatric Surgery or other surgical procedures for weight reduction; 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 or medications 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 unspecified developmental disorders that are not related to a specified medical condition, except as described in the ***Comprehensive Health Care Services*** section under *"Services Related to Treatment of Autism Spectrum Disorder"*.
- For or related to Applied Behavior Analysis, except for the treatment of Autism Spectrum Disorder as described in the ***Comprehensive Health Care Services*** section under "Services Related to Treatment of Autism Spectrum Disorder".
- 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 human donor milk.
- 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.
- For transportation services, except as described under *"Ambulance Services"* in the ***Comprehensive Health Care Services*** section of this Certificate.
- For any self-injectable and other self-administered drugs purchased from a Physician and administered in his/her office.
- Which are not specifically named as Covered Services subject to any other specific exclusions and limitations in this Certificate.

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 this Certificate (see "*Plan's Right of Recoupment*" in the ***General Provisions*** section). You must provide to us all documents needed to enforce our rights under this provision.

General Provisions

This section tells Benefits to which you are entitled:

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

BENEFITS TO WHICH YOU ARE ENTITLED

We provide only the Benefits specified in this Certificate.

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

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

PRIOR APPROVAL

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

NOTICE AND PROPERLY FILED CLAIM

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

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

LIMITATION OF ACTIONS

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

PAYMENT OF BENEFITS

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

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

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

Benefits under this Certificate will be based upon the Allowable Charge (as we determine) for Covered Services. A Network Provider may collect any Deductible, Copayment and/or Coinsurance amounts applicable to your coverage, but you will not be responsible for any amounts that exceed the Allowable Charge 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.

BALANCE BILLING AND OTHER PROTECTIONS

Federal requirements, including but not limited to the Consolidated Appropriations Act, may impact your Benefits. Blue Cross and Blue Shield of Oklahoma will apply federal requirements to your Benefit plan, where applicable.

For some types of Out-of-Network care, your health care Provider may not bill you more than your in-network cost-sharing levels. If you receive the types of care listed below, your cost-share will be calculated as if you received services from an in-network Provider. Those cost-share amounts will apply to any in-network Deductible and Out-of-Pocket Maximums.

- Emergency Care from facilities or Providers who do not participate in your Network;
- Care furnished by non-participating Providers during your visit to an in-network facility; and
- Air ambulance services from Non-Participating Providers, if your plan covers in-network air ambulance services.

There are limited instances when an Out-of-Network Provider of the care listed above may send you a bill for up to the amount of that Provider's billed charges. You are only responsible for payment of the Out-of-Network Provider's billed charges if, in advance of receiving services, you signed a written notice that informed you of:

- the Provider's Out-of-Network status;
- in the case of services received from an Out-of-Network Provider at an in-network facility, a list of in-network Providers at the facility who could offer the same services;
- information about whether Prior Authorization or other care management limitations may be required in advance of services; and
- a good faith estimate of the Provider's charges.

Your Provider cannot ask you to be responsible for paying billed charges for certain types of services, including emergency medicine, anesthesiology, pathology, radiology, and neonatology, and other specialists as may be defined by applicable law.

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 Arrangements". These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross and Blue Shield Association. Whenever you access Covered Services outside of our service area, you will receive it from one of two kinds of Providers. Most Providers ("participating Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some Providers ("non-contracting Providers") do not contract with the Host Blue. We explain how we pay both types below.

- **BlueCard® Program**

  Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, we will remain responsible for what we agreed to in the Certificate. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating Providers.

  For Inpatient facility services received in a Hospital, the Host Blue's participating Provider is required to obtain Prior Authorization. If Prior Authorization is not obtained, Benefits will be reduced based on the Host Blue's contractual agreement with the Provider, and the Member will be held harmless for the Provider sanction.

  Whenever you receive 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 past pricing of claims, as noted above. However, such adjustments will not affect the price we use for your claim because they will not be applied after a claim has already been paid.

- **Non-Participating Health Care Providers Outside the Plan's Service Area**
  - **Liability Calculation**

    In general, when Covered Services are provided outside of the Plan's service area by non-participating Providers, the amount(s) a Subscriber pays for such services will be calculated using the methodology described in the Certificate for non-participating Providers located inside our service area. You may be responsible for the difference between the amount that the non-participating Provider bills and the payment the Plan will make for the Covered Services as set forth in this paragraph. Payments for out-of-network emergency services are governed by applicable federal and state law.
  - **Exceptions**

    In some exception cases, the Plan may, but is not required to, in its sole and absolute discretion, negotiate a payment with such non-participating Provider on an exception basis. If a negotiated payment is not available, then the Plan may make a payment based on the lesser of:

    - the amount calculated using the methodology described in the Certificate for non-participating Providers located inside our service area (described above); or
    - the following:
      - for professional Providers, make a payment based on publicly available Provider reimbursement data for the same or similar professional services, adjusted for geographical differences where applicable; or
      - for Hospital or facility Providers, make a payment based on publicly available data reflecting the approximate costs that Hospitals or facilities have incurred historically to provide the same or similar service, adjusted for geographical differences where applicable, plus a margin factor for the Hospital or facility.

    In these situations, you may be liable for the difference between the amount that the non-participating Provider bills and the payment Blue Cross and Blue Shield of Oklahoma will make for the Covered Services as set forth above.

- **Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees**

  Federal or state laws or regulations may require a surcharge, tax or other fee that applies to insured Employer accounts. If applicable, Blue Cross and Blue Shield of Oklahoma will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

- **Value-Based Programs**

  If you receive Covered Services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host blue passes these fees to the Plan through average pricing or fee schedule adjustments.

- **Blue Cross Blue Shield Global Core**

  If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), you may be able to take advantage of Blue Cross Blue Shield Global Core when accessing Emergency Care Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield Global Core assists you with accessing a network of Inpatient, Outpatient and professional Providers, the network is not served by a Host Blue. As such, when you receive care from Providers outside the BlueCard service area, you will typically have to pay the Providers and submit the claims yourself to obtain reimbursement for these services.

  If you need medical assistance services (including locating a doctor or Hospital) outside the BlueCard service area, you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a Physician appointment or hospitalization, if necessary.

  - **Emergency Care Services**

    This Certificate covers only limited health care services received outside of the United States. As used in this section, "Out-of-Area Covered Services" include Emergency Care, and Urgent Care obtained outside the geographic area we serve. Follow-up care following an emergency is also available. Any other services will not be eligible for Benefits unless authorized by the Plan.

  - **Inpatient Services**

    In most cases, if you contact the service center for assistance, Hospitals will not require you to pay for covered Inpatient services, except for your Deductibles, Copayments and Coinsurance, etc. In such cases, the Hospital will submit your claims to the service center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for Covered Services.

  - **Outpatient Services**

    Physicians, Urgent Care centers and other Outpatient Providers located outside the Blue Card service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Services.

  - **Submitting a Blue Cross Blue Shield Global Core Claim**

    When you pay for Covered Services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the Provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from the Plan, the service center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

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.

MEMBER DATA SHARING

You may, under certain circumstances, as specified below, apply for and obtain, subject to any applicable terms and conditions, replacement coverage. The replacement coverage will be that which is offered by Blue Cross and Blue Shield of Oklahoma, a division of Health Care Service Corporation, or, if you do not reside in the Blue Cross and Blue Shield of Oklahoma service area, by the Host Blue whose service area covers the geographic area in which you reside. The circumstances mentioned above may arise in various circumstances, such as from involuntary termination of your health coverage sponsored by the Employer. As part of the overall plan of Benefits that Blue Cross and Blue Shield of Oklahoma offers to you, if you do not reside in the Blue Cross and Blue Shield of

Oklahoma service area, Blue Cross and Blue Shield of Oklahoma may facilitate your right to apply for and obtain such replacement coverage, subject to applicable eligibility requirements, from the Host Blue in which you reside. To do this we may (1) communicate directly with you and/or; (2) provide the Host Blue whose service area covers the geographic area in which you reside, with your personal information and may also provide other general information relating to your coverage under the Certificate the Employer has with Blue Cross and Blue Shield of Oklahoma to the extent reasonably necessary to enable the relevant Host Blue to offer you coverage continuity through replacement coverage.

DETERMINATION OF BENEFITS AND UTILIZATION REVIEW

The Plan, as claims administrator, is hereby granted discretionary authority to interpret the terms and conditions of this Certificate 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 or if such service or supply is Experimental, Investigational and/or Unproven. The Plan's 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.bcbsok.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 this Certificate.

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

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

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

RESCISSION OF COVERAGE

Rescission is the retroactive cancellation or discontinuance of coverage due to an act, practice, or omission that constitutes fraud or an intentional misrepresentation of a material fact by you or by a person seeking coverage on your behalf. A retroactive cancellation or discontinuance of coverage due to failure to timely pay required premiums or contributions toward the cost of coverage (including COBRA premiums), a cancellation or discontinuance initiated by you or your authorized representative or a prospective cancellation or discontinuance of coverage is not considered a rescission. Rescission is subject to 30 days' prior notification and is retroactive to the Effective Date. In the event of such cancellation, the Plan may deduct from the premium refund any amounts made in claim payments during this period, and you 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 Certificate, the Plan may at its option make an offer to reform the Certificate already in force and/or change the rating category/level. In the event of reformation, the Certificate 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 call a Customer Service Representative at the toll-free number listed on the back of your Identification Card for additional information regarding your appeal rights concerning rescission and/or reformation. If the decision to rescind coverage is upheld at the completion of the internal appeal process, external review by an Independent Review Organization may be requested.

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.

The decision regarding the course of treatment and receipt of health care services is a matter entirely between you and your Provider.

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

GROUP RELATIONSHIPS

The Group is your agent, not our agent.

VALUE BASED DESIGN PROGRAMS

The Plan has the right to offer health and behavior wellness, incentive, maintenance, or improvement programs that allow for a reward, a contribution, a differential in premiums or in medical, Prescription Drug or equipment Deductibles, Copayments, Coinsurance or costs, or a combination of these incentives for participation in any such program offered or administered by the Plan or an entity chosen by the Plan to administer such program. In addition, discount or incentive programs for various health or wellness-related, insurance-related or other items and services may be available from time to time. Such programs may be discontinued without notice.

Individuals unable to participate in these incentives or disincentives due to an adverse health factor shall not be penalized based upon an adverse health status and, unless otherwise permitted by law, the Plan will allow a reasonable alternative to any individual for whom it is unreasonably difficult, due to a medical condition, to satisfy otherwise applicable wellness program standards.

Contact the Plan for additional information regarding any Value Based Programs available to you.

IDENTITY THEFT PROTECTION SERVICES

As a Subscriber, the Plan makes available at no additional cost to you identity theft protection services, including credit monitoring, fraud detection, credit/identity repair to help protect your information. These identity theft protection services are currently provided by the Plan's designated outside vendor and acceptance or declination of these services is optional to you. Subscribers who wish to accept such identity theft protection services will need to individually enroll in the program online at www.bcbsok.com or by telephone at the number shown on your Identification Card. Services may automatically end when the person is no longer an eligible Subscriber. Services may change or be discontinued at any time with or without notice and the Plan does not guarantee that a particular vendor or service will be available at any given time.

ACTUARIAL VALUE

The use of a metallic name in your ***Schedule of Benefits***, 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.

COORDINATION OF BENEFITS

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

- **Definitions**

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

"Other Contract" means any arrangement, 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 trusteed plans, union welfare plans, employer organization plans or employee benefit organization plans;
- Coverage toward the cost of which any employer has contributed, or with respect to which any employer has made payroll deduction;
- 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 Certificate 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 Certificate are an indebtedness which we may recover. Our acceptance of your premiums or payment of Benefits under this Certificate does not waive our rights to enforce these provisions in the future.

- **Plan's Right of Recoupment for Overpayments**

  If the Plan pays Benefits for eligible expenses incurred by you or your Dependents and it is found that the payment was more than it should have been, or was made in error ("Overpayment"), the Plan has the right to obtain a refund of the Overpayment from: (i) the person to, or for whom, such Benefits were paid, or (ii) any insurance company or plan, or (iii) any other persons, entities or organizations, including, but not limited to, Participating Providers or Out-of-Network Providers.

  If no refund is received, the Plan (in its capacity as insurer or administrator) has the right to deduct any refund for any Overpayment due, up to an amount equal to the Overpayment, from:

  - any future Benefit payment made to any person or entity under this Certificate, whether for the same or a different Subscriber; or
  - any future benefit payment made to any person or entity under a self-funded benefit program administered by the Plan; or,
  - any future benefit payment made to any person or entity under another group benefit plan or individual

policy insured by the Plan; or

- any future benefit payment, or other payment, made to any person or entity; or
- any future payment owed to one or more Participating Providers or Out-of-Network Providers.

Further, Blue Cross Blue Shield of Oklahoma has the right to reduce your Benefit plan's or policy's payment to a Provider by the amount necessary to recover another Blue Cross Blue Shield plan's or policy's overpayment to the same Provider and to remit the recovered amount to the other Blue Cross Blue Shield plan or policy.

- **Plan's Right of Recoupment for Third Party Proceeds**

  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 Certificate more than 24 months after the payment is made, unless:

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

PLAN/ASSOCIATION RELATIONSHIP

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

THE PLAN'S SEPARATE FINANCIAL ARRANGEMENTS WITH PRESCRIPTION DRUG PROVIDERS

The Plan hereby informs you that it has contracts, either directly or indirectly, with Participating Prescription Drug Providers for the provision of, and payment for, Prescription Drug services to all persons entitled to Prescription Drug Benefits under individual certificates, group health insurance policies and contracts to which the Plan is a party, including this Certificate, and that pursuant to the Plan's contracts with Participating Prescription Drug Providers, under certain circumstances described therein, the Plan may receive discounts for Prescription Drugs dispensed to you. Actual discounts used to calculate your share of the cost of Prescription Drugs will vary. Some discounts are currently based on 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 the Plan 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 Certificate. Additional information about these types of fees or the amount of these fees is available upon request. The maximum that Prime will receive from any pharmaceutical manufacturer for certain administrative fees will be 3% of the total sales for all rebatable products of such manufacturer dispensed during any given Calendar Year to members of the Plan and other Blue Plan operating divisions.

THE PLAN'S SEPARATE FINANCIAL ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS

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

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

Subscriber Rights

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

You have the right to:

- confidentiality of health information;
- receive Medically Necessary and appropriate care and service as defined in this Certificate;
- receive courteous and respectful care and services from the Plan's 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 Prior Authorization request;
- designate an authorized representative to act on your behalf in pursuing a Benefit claim or appeal of an adverse Benefit determination.

Claims Filing Procedures

This coverage begins to pay only after any applicable Deductible and/or Copayment you incur toward eligible expenses shows on our records. When your Physician, Hospital or other Provider of health care services submits bills for you, your Deductible and/or Copayment will be recorded automatically and then your coverage will begin its share of the payment. If you file your own claims, you must submit copies of all your bills, even those you must pay to meet your Deductible and/or Copayment. Then our records will show that you have incurred the Deductible and/or Copayment 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. When you receive Covered Services from a Network Provider, 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 Certificate 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 Preferred Participating Pharmacies and 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 the Benefits available under your Prescription Drug program. Be sure to include the diagnosis and the payment receipt with your completed claim form. If the Prescription Drug is covered under this program, any 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 nearest Plan office.

Be sure to fill out the claim form completely, sign it, and attach the Provider's or Pharmacy's itemized statement. For health claims, you may send the completed claim form to:

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

For Prescription Drug claims, you may send the completed claim form to:

Prime Therapeutics
P.O. Box 25136
Lehigh Valley, PA 18002-5136

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); and
- Diagnosis.

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

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

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

DIRECT CLAIMS LINE

We have a direct line for claims and membership inquiries. You may call 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.

Complaint/Appeal Procedure

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

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

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

CLAIM DETERMINATIONS

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

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

IF A CLAIM IS DENIED OR NOT PAID IN FULL

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

If the claim is denied in whole or in part, you will receive a written notice from 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 or administrative basis 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 codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
- An explanation of our internal review/appeals and external review processes (and how to initiate a review/appeal or external review);
- In certain situations, a statement in non-English language(s) that the written notice of the claim denial and certain other Benefit information may be available (upon request) in such non-English language(s);
- In certain situations, a statement in non-English 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, 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, Investigational and/or Unproven 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. There are three types of claims, as defined below.

- **"Urgent Care Claim"** is any pre-service request for Benefits that requires *"Prior Authorization"*, as described in this Certificate, for Benefits for Medical Care or treatment with respect to which the application of regular time periods for making health claim decisions could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment.
- **"Pre-Service Claim"** is any non-urgent request for Benefits or a determination with respect to which the terms of the Benefit plan condition receipt of the Benefit on approval of the Benefit in advance of obtaining Medical Care.
- **"Post-Service Claim" (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*

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

*You do not need to submit 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

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

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

POST-SERVICE CLAIMS

Type of Notice or Extension	**Timing**
If your claim is incomplete, we must notify you within:	**30 days**
If you are notified that your claim is incomplete, you must then provide completed claim information to us within:	**45 days** after receiving notice
We must notify you of any adverse claim determination:	
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 and/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 Certificate) before the end of the approved treatment period, that is also an Adverse Benefit Determination.

  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 the information needed to review the appeal. Additional information must be submitted within 24 hours of request. The Plan shall render a determination on the appeal as soon as possible (taking into account medical exigencies) but no later than 72 hours after it receives the initial request, or within 48 hours after it receives the missing information (if the initial request is incomplete).

- ***How to Appeal 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 Prior Authorization, or any other determination made by us in accordance with the Benefits and procedures detailed in your Certificate.

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

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

  – Within 180 days after you receive notice of an Adverse Benefit Determination, you may 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, call 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 and/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, or the contractual or administrative basis 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 a standard external review by an Independent Review Organization (IRO) must be submitted within four months after you receive notice of the internal appeal determination. 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 request an **expedited external review** of our denial before your internal review rights have been exhausted. 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.

You or your authorized representative may file a request for a standard or expedited 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
Telephone: 1-800-522-0071
(Oklahoma only) 405-521-2828

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
400 NE 50th Street
Oklahoma City, OK 73105
http://www.ok.gov/oid/Consumer/index.html
Telephone: 1-800-522-0071 or 405-521-2828

Your ERISA Rights

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

ERISA RIGHTS

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

ASSISTANCE WITH YOUR QUESTIONS

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

Definitions

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

ALLOWABLE CHARGE

The charge that the Plan will use as the basis for Benefit determination for Covered Services you receive under this Certificate. 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 Drugs and Related Services:***
  - **Participating Pharmacies (including Participating Mail-Order Pharmacy, Extended Supply Network Pharmacy and Specialty Pharmacy)** – the Pharmacy's usual charge, not to exceed the amount the Pharmacy has agreed to accept as payment for Covered Services in accordance with a Participating Pharmacy agreement.
  - **Out-of-Network 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 health care 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 Certificate.

BLUECARD PROVIDER

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

CALENDAR YEAR

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

CARE COORDINATION

Organized, information-driven patient care activities intended to facilitate the appropriate responses to Subscriber's health care needs across the continuum of care.

CARE COORDINATOR FEE

A fixed amount paid by a Blue Cross and/or Blue Shield Plan to Providers periodically for Care Coordination under a Value-Based Program.

COBRA CONTINUATION COVERAGE

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

COINSURANCE

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

CONTRACT/GROUP CONTRACT

This agreement including, but not limited to, the Group's application and any amendments between your Group 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 any Copayments applicable to your coverage.

COVERED DRUG

Any Prescription Drug or self-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 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 Certificate, *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.

COVERED SERVICE

A service or supply shown in this Certificate 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 dollar amount of Covered Services that a Subscriber must incur during each Benefit Period before the Plan will start to pay its share of the remaining Covered Services. Refer to the ***Schedule of Benefits*** for any Deductibles applicable to your coverage.

DEPENDENT

A Subscriber other than the Member as shown in the ***Eligibility, Enrollment, Changes & 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 in accordance with the Employer's guidelines. All provisions of this Certificate (with the exception of COBRA Continuation Coverage), that pertain to a spouse also pertain to a Domestic Partner once eligibility is determined. Check with your Group Administrator for Domestic Partner provisions unique to your Group's coverage.

NOTE: A Domestic Partner is not recognized as a spouse for certain federally regulated programs, such as COBRA Continuation Coverage and Medicare.

DOMESTIC PARTNERSHIP

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

DRUG LIST

A list of all drugs that may be covered under the ***Outpatient Prescription Drugs and Related Services*** section of this Certificate. A current list is available on our Web site at https://www.bcbsok.com/member/prescription-drug-plan-information/drug-lists. You may also contact a Customer Service Representative at the telephone number shown on the back of your Identification Card for more information.

DURABLE MEDICAL EQUIPMENT

Equipment which 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 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 and meets the Plan's criteria of Medical Necessity for the given diagnosis.

EFFECTIVE DATE

The date when your coverage begins.

ELIGIBLE PERSON

A person entitled to apply to be a Member as specified in the ***Eligibility, Enrollment, Changes & 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 (or, with respect to a pregnant woman, the health of the woman or her unborn child);
- serious impairment to bodily function; or
- serious dysfunction of any bodily organ or part; or
- with respect to a pregnant woman who is having contractions:
  - there is inadequate time to effect a safe transfer to another Hospital before delivery, or
  - transfer may pose a threat to the health or safety of the woman or the unborn child.

EMPLOYEE

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

EMPLOYER

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

EXPERIMENTAL/INVESTIGATIONAL/UNPROVEN

A drug, device, biological product or medical treatment or procedure is Experimental, Investigational and/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.

Approval by a governmental or regulatory agency will be taken into consideration by the Plan in assessing Experimental/Investigational/Unproven status of a drug, device, biological product, or medical treatment or procedure but will not be determinative.

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. To determine which drugs are Preferred Generic Drugs or Non-Preferred Generic Drugs, refer to the Drug List on the Plan's Web site at https://www.bcbsok.com/member/prescription-drug-plan-information/drug-lists. You may also contact a Customer Service Representative at the number shown on your Identification Card for more information. All products identified as a Generic Drug by the drug product database, manufacturer, Pharmacy or your Physician may not be considered a Generic Drug by the Plan.

GROUP

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

GROUP HEALTH PLAN

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

HABILITATION CARE

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include Physical Therapy, Occupational Therapy, Speech Therapy and other services for people with disabilities in a variety of Inpatient and/or Outpatient settings.

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 Health and Substance Use Disorder;
  - Place for the treatment of alcoholism, or drug addiction;
  - Place for the provision of Hospice care;
  - Place for the provision of Rehabilitation Care or Habilitation 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.

IN HOME HEALTH ASSESSMENT

Covered Services may include, but are not limited to, health history and blood pressure and blood sugar level screening. The assessment is designed to provide you with information regarding your health that can be discussed with your health care Provider, and is not a substitute for diagnosis, management and treatment by your health care Provider.

INFUSION SUITE

An alternative to Hospital and clinic-based infusion settings where specialty medications can be infused.

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 Health and Substance Use Disorder, drug addiction, or alcoholism, or specializes in the treatment of co-occurring Mental Health and Substance Use Disorder. 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 Health and Substance Use Disorder.

LEGEND DRUGS

Drugs, biologicals, or compounded prescriptions which are required by law to have a label stating "Caution – Federal Law Prohibits Dispensing Without a Prescription", and which are approved by the U.S. Food and Drug Administration (FDA) for a particular use or purpose.

LICENSED PRACTICAL OR VOCATIONAL NURSE (LPN OR LVN)

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

LIFE-THREATENING DISEASE OR CONDITION

For the purposes of a clinical trial, any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

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 HEALTH AND SUBSTANCE USE DISORDER

Any condition or disorder involving a mental health condition or substance use disorder listed under any of the diagnostic categories in the mental disorders section of the most recent edition of the International Classification of Disease or in the mental disorders section of the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

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, that the Subscribers must reside, live or work in to be eligible to apply for coverage under this Certificate. 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.bcbsok.com.

NON-PREFERRED BRAND DRUG

A brand-name Prescription Drug which appears on the applicable Drug List and is identified as a Non-Preferred Brand Drug. The Drug List is available on the Plan's Web site at https://www.bcbsok.com/member/prescription-drug-plan-information/drug-lists.

NON-PREFERRED GENERIC DRUG

A Generic Drug which appears on the applicable Drug List and is identified as a Non-Preferred Generic Drug. The Drug List is available on the Plan's Web site at https://wwwbcbsok.com/member/prescription-drug-plan-information/drug-lists.

NON-PREFERRED SPECIALTY DRUG

A Specialty Drug which appears on the applicable Drug List and is identified as a Non-Preferred Specialty Drug. The Drug List is available on the Plan's Web site at https://wwwbcbsok.com/member/prescription-drug-plan-information/drug-lists.

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 for Covered Services received from Network Providers. 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 services received from Out-of-Network Providers, amounts in excess of the Allowable Charge or charges for any services that are not covered under this Certificate.

OUTPATIENT

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

PARTICIPATING PHARMACY

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.

To find a Pharmacy in the Participating Pharmacy Network, please refer to the Plan's Web site at https://www.bcbsok.com/provider_finder/important_info_rx.html 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 state and federally licensed establishment that is physically separate and apart from any Provider's office, and where Legend Drugs and devices are dispensed under Prescription Orders to the general public by a pharmacist licensed to dispense such drugs and devices under the law of the state in which he or she practices.

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.

POST-SERVICE MEDICAL NECESSITY REVIEW

A Post-Service Medical Necessity Review, sometimes referred to as a retrospective review or post-service claims request, is the process of determining coverage after treatment has already occurred and is based on Medical Necessity guidelines.

PREDETERMINATION

Predetermination is an optional voluntary review of a Provider's recommended medical procedure, treatment or test, that does not require Prior Authorization, to make sure it meets approved Blue Cross and Blue Shield medical policy guidelines and Medical Necessity requirements.

PREFERRED BRAND DRUG

A brand-name Prescription Drug which appears on the applicable Drug List and is identified as a Preferred Brand Drug. The Drug List is available on the Plan's Web site at https://www.bcbsok.com/member/prescription-drug-plan-information/drug-lists.

PREFERRED SPECIALTY DRUG

A Specialty Drug which appears on the applicable Drug List and is identified as a Preferred Specialty Drug. The Drug List is available on the Plan's Web site at https://wwwbcbsok.com/member/prescription-drug-plan-information/drug-lists.

PREFERRED PARTICIPATING PHARMACY

A Participating Pharmacy which has a written agreement with the Plan to provide pharmaceutical services to Subscribers or an entity chosen by the Plan to administer its Prescription Drug program that has been designated as a "Preferred Participating Pharmacy".

To find a Preferred Participating Pharmacy, please refer to the Plan's Web site at www.bcbsok.com or call a Customer Service Representative at the number shown on your Identification Card.

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

PREVENTIVE CARE SERVICES

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

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

PRIOR AUTHORIZATION

The process that determines in advance the Medical Necessity or Experimental, Investigational or Unproven nature of certain care and services under the Certificate. Prior Authorization does not guarantee that the care and services you receive are eligible for Benefits under the Certificate. At the time your claims are submitted, they will be reviewed in accordance with the terms of the Certificate.

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.

PROVIDER INCENTIVE

An additional amount of compensation paid to a health care Provider by a Blue Cross and/or Blue Shield Plan, based on the Provider's compliance with agreed-upon procedural and/or outcome measures for a particular population of Subscribers.

PSYCHIATRIC HOSPITAL

A Provider that is a state licensed Hospital that primarily specializes in the treatment of severe Mental Health and Substance Use Disorder.

QUALIFYING EVENT

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

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

REGISTERED NURSE (RN)

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

REHABILITATION CARE

Services, including devices, provided to help a person regain, maintain or prevent deterioration of a skill or function that has been acquired but then lost or impaired due to illness, injury or a disabling condition.

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 Health and Substance Use Disorder. This care is medically monitored, with 24-hour Physician availability and 24-hour onsite nursing services. It does not include half-way houses, wilderness programs, supervised living, group homes, boarding houses or other facilities or programs 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 select 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 Health and Substance Use Disorder, drug addiction, alcoholism 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. To determine which drugs are Preferred Specialty Drugs or Non-Preferred Specialty Drugs, refer to the Drug List on the Plan's Web site at https://www.bcbsok.com/member/prescription-drug-plan-information/drug-lists] 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 or her Dependents (if any) covered under this Certificate.

SURGERY

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

THERAPY SERVICE

The following services and supplies ordered by a Physician or other Provider when used to treat and promote your recovery from an illness or injury, or that are provided in order for a person to attain, maintain or prevent deterioration of a skill or function never learned or acquired due to a disabling condition:

- **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.

- **Infusion Therapy –** the administration of medication through a needle or catheter. Typically, "Infusion Therapy" means that a drug is administered intravenously, but the term also may refer to situations where drugs are provided through other non-oral routes, such as intramuscular injections and epidural routes (into the membranes surrounding the spinal cord). Infusion Therapy is prescribed when a patient's condition is so severe that it cannot be treated effectively by oral medications.
- **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, to restore, attain or maintain maximum function, and to prevent disability or deterioration of a skill or function resulting from a disabling condition, disease, injury or loss of body part.
- **Occupational Therapy** – treatment of a physically disabled person by means of constructive activities designed and adapted to promote the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role.
- **Speech Therapy –** treatment for the correction of a speech impairment resulting from disease, Surgery, injury, congenital and developmental anomalies or previous therapeutic processes.

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) occurring 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, cigarettes, cigars, pipe tobacco, smokeless tobacco, snuff, electronic cigarettes, etc. For additional information, please call Customer Service at the number listed on your Identification Card or visit our Web site at 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 similarly situated person who is not disabled.

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.

URGENT CARE

The delivery of Medical Care by a Network Urgent Care Provider dedicated to the delivery of scheduled or unscheduled, care outside of a Hospital emergency room (or other comparable facility) or Physician's office. The necessary medical care is for a condition that is not life-threatening.

VALUE-BASED DESIGN PROGRAM

An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local Providers that is evaluated against cost and quality metrics/factors.

VIRTUAL VISITS

Consultation with a licensed Provider through interactive video, or other communication technology allowed by applicable law, via online portal or mobile application.

BlueCross BlueShield of Oklahoma

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NO SURPRISES ACT AMENDMENT

IT IS AGREED that the Certificate of Benefits to which this amendment is issued for attachment is amended as set forth below:

The terms of this Amendment supersede the terms of the Certificate to which this Amendment is attached and becomes a part of the Certificate. Unless otherwise required by Federal or Oklahoma law, in the event of a conflict between the terms on this Amendment and the terms of the Certificate, the terms on this Amendment apply. However, definitions set forth in this Amendment are for purposes of this Amendment only. Additionally, for purposes of this Amendment, references to you and your mean any Subscriber, including Members and Dependents.

The Certificate is hereby amended as indicated below:

I. <u>Continuity of Care</u>

If you are under the care of a participating Provider as defined in the Certificate who stops participating in the Plan's network (for reasons other than failure to meet applicable quality standards, including medical incompetence or professional behavior, or fraud), you may be able to continue coverage for that Provider's Covered Services at the participating Provider Benefit level if one of the following conditions is met:

1. You are undergoing a course of treatment for a serious and complex condition,
2. You are undergoing institutional or inpatient care,
3. You are scheduled to undergo nonelective surgery from the Provider (including receipt of postoperative care from such Provider with respect to such surgery),
4. You are pregnant or undergoing a course of treatment for your pregnancy, or
5. You are determined to be terminally ill.

A serious and complex condition is one that (1) for an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm (for example, if you are currently receiving chemotherapy, radiation therapy, or post-operative visits for a serious acute disease or condition), and (2) for a chronic illness or condition, is (i) life-threatening, degenerative, disabling or potentially disabling, or congenital, and (ii) requires specialized medical care over a prolonged period of time.

Continuity coverage described in this provision shall continue until the treatment is complete but will not extend for more than 90 days beyond the date the Plan notifies you of the Provider's termination, or any longer period provided by state law. If you are in the second or third trimester of pregnancy when the Provider's termination takes effect, continuity of coverage may be extended through delivery of the child, immediate postpartum care, and the follow-up check-up within the first six (6) weeks of delivery. You have the right to appeal any decision made for a request for Benefits under this provision, as explained in the Certificate.

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II. Federal No Surprises Act

1. Definitions

The definitions below apply only to Section II. Federal No Surprises Act, of this Amendment. To the extent the same terms are defined in both the Certificate and this Amendment, those terms will apply only to their use in the Certificate or this Amendment, respectively.

"Air Ambulance Services" means, for purposes of this Amendment only, medical transport by helicopter or airplane for patients.

"Emergency Medical Condition" means, for purposes of this Amendment only, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition: (i) placing the health of the individual, or with respect to a pregnant woman her unborn child in serious jeopardy; (ii) constituting a serious impairment to bodily functions; or (iii) constituting a serious dysfunction of any bodily organ or part.

"Emergency Services" means, for purposes of this Amendment only,

- a medical screening examination performed in the emergency department of a hospital or a freestanding emergency department;
- further medical examination or treatment you receive at a Hospital, regardless of the department of the Hospital, or a freestanding emergency department to evaluate and treat an emergency medical condition until your condition is stabilized; and
- Covered Services you receive from a non-participating provider during the same visit after your emergency medical condition has stabilized unless:
    1. Your Non-Participating Provider determines you can travel by non-medical or non-emergency transport;
    2. Your Non-Participating Provider has provided you with a notice to consent form for balance billing of services; and
    3. You have provided informed consent.

"Non-Participating Provider" means, for purposes of this Amendment only, with respect to a covered item or service, a Physician or other health care provider who does not have a contractual relationship with Blue Cross and Blue Shield of Oklahoma (BCBSOK) for furnishing such item or service under the Plan to which this Amendment is attached.

"Non-Participating Emergency Facility" means, for purposes of this Amendment only, with respect to a covered item or service, an emergency department of a hospital or an independent freestanding emergency department that does not have a contractual relationship with BCBSOK for furnishing such item or service under the Plan to which this Amendment is attached.

"Participating Provider" means, for purposes of this Amendment only, with respect to a Covered Service, a Physician or other health care provider who has a contractual relationship with BCBSOK setting a rate (above which the provider cannot bill the member) for furnishing such item or service under the Plan to which this Amendment is attached regardless whether the provider is considered a preferred or in-network provider for purposes of in-network or out-of-network Benefits under the subject Plan.

"Participating Facility" means, for purposes of this Amendment only, with respect to Covered Service, a Hospital or ambulatory surgical center that has a contractual relationship with BCBSOK setting a rate (above which the provider cannot bill the member) for furnishing such item or service under the Plan to which this Amendment is attached. Whether the provider is considered a preferred or in-network provider for purposes of in-network or out-of-network Benefits under the subject Plan.

"Qualifying Payment Amount" means, for purposes of this Amendment only, a median of contracted rates calculated pursuant to federal or state law, regulation and/or guidance.

"Recognized Amount" means, for purposes of this Amendment only, an amount determined pursuant a state law that provides a method for determining the total amount payable for the item or service (if applicable); or, if there is no state law that provides a method for determining the total amount payable for the item or service, the lesser of the Qualifying Payment Amount or billed charges.

2. **Federal No Surprises Act Surprise Billing Protections**

a. The federal No Surprises Act contains various protections relating to surprise medical bills on services performed by Non-Participating Providers and Non-Participating Emergency Facilities. The items and services included in these protections ("Included Services") are listed below.

- Emergency Services obtained from a Non-Participating Provider or Non-Participating Emergency Facility.
- Covered non-Emergency Services performed by a Non-Participating Provider at a Participating Facility (unless you give written consent and give up balance billing protections).
- Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider.

b. Claim Payments

For Included Services, the Plan will send an initial payment or notice of denial of payment directly to the Provider.

c. **Cost-Sharing**

For non-Emergency Services performed by Non-Participating Providers at a Participating Facility, and for Emergency Services provided by a Non-Participating Provider or Non-Participating Emergency Facility, the Recognized Amount is used to calculate your cost-share requirements, including Deductibles, Copayments, and Coinsurance.

For Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider, the amount used to calculate your cost-share requirements, including Deductibles, Copayments, and Coinsurance, will be the lesser of the Qualifying Payment Amount or billed charges.

For Included Services, these cost-share requirements will be counted toward your Participating Provider deductible and/or Out-of-Pocket Limit, if any.

3. Prohibition of Balance Billing

You are protected from balance billing on Included Services as set forth below.

If you receive Emergency Services from a Non-Participating Provider or non-Participating Emergency Facility, the most the Non-Participating Provider or non-Participating Emergency Facility may bill you is your in-network cost-share. You cannot be balance billed for these Emergency Services unless you give written consent and give up your protections not to be balanced billed for services you receive after you are in a stable condition.

When you receive Covered Non-Emergency Services from a Non-Participating Provider at a Participating Facility, the most those Non-Participating Providers may bill you is your Plan's in-network cost-share requirements. When you receive emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services at a Participating Facility, Non-Participating Providers can't balance bill you and may not ask you to give up your protections not to be balance billed. If you get other services at Participating Facilities, Non-Participating Providers can't balance bill you unless you give written consent and give up your protections.

If your Plan includes Air Ambulance Services as a Covered Service, and such services are provided by a Non-Participating Provider, the most the Non-Participating Provider may bill you is your in-network cost share. You cannot be balance billed for these Air Ambulance Services.

NOTE: The revisions to your Plan made by this Amendment are based upon the No Surprises Act, a federal law enacted in 2020 and effective for Plan Years beginning on or after January 1, 2022. To the extent federal regulations are adopted or additional guidance is issued by federal regulatory agencies that alter the terms of this Amendment, the regulations and any additional guidance will control over conflicting language in this Amendment.

Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

Except as changed by this amendment, all terms, conditions, limitations and exclusions of the Certificate to which this amendment is attached will remain in full force and effect.

President of Blue Cross and Blue Shield of Oklahoma

BlueCross BlueShield
of Oklahoma

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PEDIATRIC DENTAL SERVICES ADDENDUM

For Subscribers Under Age 19

The Certificate of Benefits (Certificate) to which this Addendum is attached and becomes a part is hereby amended as stated below.

This *Pediatric Dental Services Addendum* provides information about coverage for the pediatric dental services outlined below, which are specifically excluded under your ***Comprehensive Health Care Services*** Benefits. Services that are covered under your ***Comprehensive Health Care Services*** Benefits are not covered under this *Pediatric Dental Services Addendum*. All provisions in your Certificate for ***Comprehensive Health Care Services*** Benefits apply to this *Pediatric Dental Services Addendum* unless specifically indicated otherwise below.

This dental care coverage allows Subscribers to select the Provider of their choice, in or out of the Dental Care Provider Network. The Plan has designed these Benefits to deliver quality care, matched with your ***Comprehensive Health Care Services*** Benefits, at the most affordable cost, through network services. You also have the flexibility to visit an Out-of-Network Provider, with a reduction in Benefits.

For a list of Dental Care Network Providers, please contact a Customer Service Representative at the number shown on the back of your Identification Card or visit the Plan's Web site at www.bcbsok.com.

DEFINITIONS

The following definitions are added to the ***Definitions*** section of your Certificate:

- **Allowable Charge –** The charge that the Plan will use as the basis for Benefit determination for Covered Services you receive under the Certificate and this Addendum. The Plan will use the following criteria to establish the Allowable Charge for Covered Dental Services:
  - **Participating Dentist** – the amount the Dentist has agreed to accept as full payment for Covered Services.
  - **Out-of-Network Dentists** – the Dentist's usual charge for Covered Services, not to exceed the amount that the Plan would reimburse a Participating Dentist for the same services. The Subscriber may be responsible for the full amount by which the actual charges of an Out-of-Network Dentist exceed the Allowable Charge.
- **Course of Treatment –** Any number of dental procedures or treatments performed by a Dentist or Physician in a planned series. In cases where there is more than one professionally acceptable Course of Treatment or service to treat the dental condition, Benefits will be covered for the least costly Course of Treatment or service.
- **Dentist –** A professional practitioner who holds a lawful license issued by any state of the United States, or its territories, authorizing the person to practice dentistry and dental surgery in such state or territory, including, but not limited to, a Doctor of Dental Surgery (DDS) or a Doctor of Medical Dentistry (DMD).

- **Medically Necessary (or Medical Necessity) –** A specific procedure or supply provided to you is reasonably required in the judgment of the Plan, for the treatment or management of your specific dental symptom, injury, or condition and that the procedure performed is the most efficient and economical procedure that can safely be provided to you. The fact that a Dentist or Physician may prescribe, order, recommend or approve a procedure does not make such a procedure Medically Necessary. To be Medically Necessary, the procedure or supply must also conform to approved and generally accepted standards of accepted dental practice prevailing in the state when and where the procedure or supply is ordered. Such procedures or supplies are also subject to review and analysis by dental consultants, retained by the Plan. These consultants review the claim and diagnostic materials submitted in support of the claim, and based upon their professional opinions, determine the necessity and propriety of treatment.
- **Pretreatment Estimate -** A Pretreatment Estimate identifies the Plan's estimated financial liability before treatment is started. This estimate may include some or all of the following information: patient's eligibility, Covered Services, Benefit amounts payable, Deductible amounts, Coinsurance and/or maximum Benefit limitations. Such estimates are subject to change, according to the terms of the Subscriber's coverage, as set forth in "*Benefit Determination for Properly Filed Claims*" and may include an allowance for alternate Benefits. Final determination of Benefits is made upon submission of a claim to the Plan for actual payment determination, if any.

ELIGIBILITY

Children who are covered under the Blue Cross and Blue Shield of Oklahoma Certificate for ***Comprehensive Health Care Services*** Benefits, up to age 19, are eligible for coverage under this *Pediatric Dental Services Addendum.* NOTE: Once coverage is lost under the Certificate, all Benefits cease under this *Pediatric Dental Services Addendum,* except as set forth under *"Extension of Your Dental Benefits in Case of Termination"*.

SCHEDULE OF BENEFITS
FOR
PEDIATRIC DENTAL SERVICES

Your Pediatric Dental Services Benefits are highlighted below. To fully understand all the terms, conditions, limitations and exclusions which apply to your Benefits, please read your entire Certificate.

The Deductibles, Coinsurance, Benefit Period Maximums and/or Out-of-Pocket Limits below are subject to change as permitted by applicable law.

BENEFIT PERIOD	Calendar Year
DEDUCTIBLE	Your Benefits for Pediatric Dental Services are subject to the Benefit Period Deductible for *"Network Provider Services"* set forth in the ***Schedule of Benefits for Comprehensive Health Care Services.***
BENEFIT PERIOD MAXIMUM	Unlimited
OUT–OF–POCKET LIMIT	Your Benefits for Pediatric Dental Services are subject to the Out-of-Pocket Limit for *"Network Provider Services"* set forth in the ***Schedule of Benefits for Comprehensive Health Care Services.***
BENEFIT PERCENTAGE AMOUNT	The following chart shows the percentage of Allowable Charges covered by this Addendum through payments and/or contractual arrangements with Providers. These percentages apply only after your Deductible amounts have been satisfied.

COVERED SERVICES	BENEFIT PAYABLE Services Obtained From:	
	Participating Dentist	**Out-of-Network Dentist***
Diagnostic Evaluations	70% of Allowable Charge	50% of Allowable Charge
Preventive Services (Periodic Oral Evaluation and Topical Fluoride Application covered at 100%, Deductible waived)	70% of Allowable Charge	50% of Allowable Charge
Diagnostic Radiographs	70% of Allowable Charge	50% of Allowable Charge
Miscellaneous Preventive Services	70% of Allowable Charge	50% of Allowable Charge
Basic Restorative Services	70% of Allowable Charge	50% of Allowable Charge
Non-Surgical Extractions	70% of Allowable Charge	50% of Allowable Charge
Non-Surgical Periodontal Services	70% of Allowable Charge	50% of Allowable Charge
Adjunctive General Services	70% of Allowable Charge	50% of Allowable Charge
Endodontic Services	70% of Allowable Charge	50% of Allowable Charge
Oral Surgery Services	70% of Allowable Charge	50% of Allowable Charge
Surgical Periodontal Services	70% of Allowable Charge	50% of Allowable Charge
Major Restorative Services	70% of Allowable Charge	50% of Allowable Charge
Prosthodontic Services	70% of Allowable Charge	50% of Allowable Charge
Miscellaneous Restorative and Prosthodontic Services	70% of Allowable Charge	50% of Allowable Charge
Orthodontic Services		
Pediatric Orthodontic Services: Coverage limited to Subscribers with an orthodontic condition meeting Medical Necessity criteria established by the Plan (e.g., severe, dysfunctional malocclusion)	70% of Allowable Charge (Unlimited Lifetime Maximum)	50% of Allowable Charge (Unlimited Lifetime Maximum)

* For Out-of-Network Dentist services, the Allowable Charge is the Dentist's usual charge, not to exceed the amount that the Plan would reimburse a Participating Dentist for the same services. The Subscriber may be responsible for the full amount by which the actual charges of an Out-of-Network Dentist exceed the Allowable Charge.

Pediatric Dental Services

The Benefits of this section are subject to all the terms and conditions of your Certificate. Benefits are available only for services and supplies that are determined by the Plan to be "Medically Necessary", unless otherwise specified. All Covered Services listed in this section are subject to the "*Exclusions and Limitations"* (listed below) and the ***Exclusions*** section of this Certificate, which lists services, supplies, situations or related expenses that are not covered.

It is important for you to refer to your *Schedule of Benefits* above to find out what your Deductible, Coinsurance and Benefit Period Maximum will be for a Covered Service.

Your Dental Benefits include coverage for the following Covered Services as long as these services are rendered to you by a Dentist or a Physician. When the term "Dentist" is used in this Addendum, it will mean Dentist or Physician**.**

COVERED DENTAL SERVICES:

DIAGNOSTIC EVALUATIONS

Diagnostic evaluations aid the Dentist in determining the nature or cause of a dental disease and include:

- Periodic oral evaluations for established patients.
- Problem-focused oral evaluations, whether limited, detailed or extensive.
- Comprehensive oral evaluations for new or established patients.
- Comprehensive periodontal evaluations for new or established patients.
- Oral evaluations of children under the age of three, including counseling with primary caregiver.
- Oral examinations – oral exams are limited to one every 6 months.

Benefits for periodic and comprehensive oral evaluations are limited to a combined maximum of two every 12 months.

PREVENTIVE SERVICES

Preventive services are performed to prevent dental disease. Covered Services include:

- Prophylaxis – Professional cleaning, scaling and polishing of the teeth. Benefits are limited to two cleanings every 12 months.
- Topical Fluoride Application – Benefits for Fluoride Application are limited to two applications every 12 months.

Special Provisions Regarding Preventive Services

Cleanings include associated scaling and polishing procedures.

Following active periodontal treatment, Benefits are available for a combination of two prophylaxes and two periodontal maintenance treatments (see "*Non-Surgical Periodontal Services*") every 12 months.

DIAGNOSTIC RADIOGRAPHS

Diagnostic radiographs are x-rays taken to diagnose a dental disease, including their interpretations, and include:

- Full-mouth (intraoral complete series) and panoramic films – Benefits are limited to a combined maximum of one every 36 months.
- Bitewing films – Benefits are limited to two sets every 12 months.
- Intraoral periapical films, as Medically Necessary for diagnosis.

MISCELLANEOUS PREVENTIVE SERVICES

Miscellaneous preventive services are other services performed to prevent dental disease and include:

- Sealants – Benefits for sealants are limited to Subscribers under age 19 and are limited to permanent molars only.
- Space Maintainers.

BASIC RESTORATIVE SERVICES

Basic restorative services are restorations necessary to repair basic dental decay, including tooth preparation, all adhesives, bases, liners and polishing. Covered Services include:

- Amalgam restorations.
- Resin-based composite restorations.

NON-SURGICAL EXTRACTIONS

Non-surgical extractions are non-surgical removal of tooth and tooth structures and include:

- Removal of retained coronal remnants – deciduous tooth.
- Removal of erupted tooth or exposed root.

NON-SURGICAL PERIODONTAL SERVICES

Non-surgical periodontal service is the non-surgical treatment of a dental disease in the supporting and surrounding tissues of the teeth (gums) and includes:

- Periodontal scaling and root planing.
- Additional scaling in the presence of generalized moderate to severe gingival inflammation is limited to once every 6 months combined with prophylaxes and periodontal maintenance.
- Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis limited to once every 12 months.
- Periodontal maintenance procedures – Benefits are limited to four every 12 months in combination with routine oral prophylaxis and must be performed following active periodontal treatment.

ADJUNCTIVE GENERAL SERVICES

Adjunctive General Services include:

- Palliative treatment (emergency) of dental pain, and when not performed in conjunction with a definitive treatment.
- Deep sedation/general anesthesia and intravenous/non-intravenous conscious sedation – By report only and when determined to be Medically Necessary for documented Subscribers with a disability or for a justifiable medical or dental condition. A person's apprehension does not constitute Medical Necessity.
- Therapeutic parenteral drugs – therapeutic parenteral drugs will be covered for Subscribers under age 19.

ENDODONTIC SERVICES

Endodontics is the treatment of dental disease of the tooth pulp and includes:

- Therapeutic pulpotomy and pulpal debridement, when performed as a final endodontic procedure. These services are considered part of the root canal procedure if root canal therapy is performed within 45 days of services.
- Root canal therapy, including treatment plan, clinical procedures, working and post-operative radiographs and follow-up care.
- Apexification/recalcification procedures and apicoectomy/periradicular services including surgery, retrograde filling, root amputation and hemisection.

ORAL SURGERY SERVICES

Oral surgery means the procedures for surgical extractions and other dental surgery under local anesthetics and includes:

- Surgical tooth extractions.
- Alveoloplasty and vestibuloplasty.
- Excision of benign odontogenic tumor/cysts.
- Excision of bone tissue.
- Incision and drainage of an intraoral abscess.
- Other Medically Necessary surgical and repair procedures not specifically excluded in this Addendum.

Intraoral soft tissue incision and drainage is only covered when it is provided as the definitive treatment of an abscess. Routine follow-up care is considered part of the procedure.

SURGICAL PERIODONTAL SERVICES

Surgical periodontal service is the surgical treatment of a dental disease in the supporting and surrounding tissues of the teeth (gums) and includes:

- Gingivectomy or gingivoplasty and gingival flap procedures (including root planing) – Benefits are limited to one per quadrant every 24 months.
- Clinical crown lengthening.
- Osseous surgery, including flap entry and closure – Benefits are limited to one per quadrant every 24 months. In addition, osseous surgery performed in a limited area and in conjunction with crown lengthening on the same date of service, by the same Dentist, and in the same area of the mouth, will be processed as crown lengthening in the absence of periodontal disease.
- Osseous grafts – Benefits are limited to one per site every 24 months. Benefits are not available for bone grafts in conjunction with extractions, apicoectomy or any non-covered service or non-covered implants.

- Soft tissue grafts/allografts (including donor site) – Benefits are limited to one per site every 24 months.
- Distal or proximal wedge procedure.

Surgical periodontal services performed in conjunction with the placement of crowns, inlays, onlays, crown buildups, posts and cores or basic restorations are considered part of the restoration.

MAJOR RESTORATIVE SERVICES

Restorative services restore tooth structures lost as a result of dental decay or fracture and include:

- Single crown restorations.
- Gold foil and inlay/onlay restorations.
- Labial veneer restorations.

Benefits for major restorations are limited to one per tooth every 60 months whether placement was provided under this Addendum or under any prior dental coverage, even if the original crown was stainless steel.

PROSTHODONTIC SERVICES

Prosthodontics involves procedures Medically Necessary for providing artificial replacements for missing natural teeth and includes:

- Complete and removable partial dentures – Benefits will be provided for the initial installation of removable complete, immediate or partial dentures, including any adjustments, relines or rebases during the six-month period following installation. Benefits for replacements are available, whether placement was provided under this Addendum or under any prior dental coverage. Benefits will not be provided for replacement of complete or partial dentures due to theft, misplacement or loss.
- Denture reline/rebase procedures – Benefits will be limited to one in a 36-month period after the initial 6-month period following initial placement.
- Fixed bridgework – Benefits will be provided for the initial installation of a bridgework, including inlays/onlays and crowns. Benefits are available, whether placement was under this Addendum or under any prior dental coverage.

  NOTE: Tissue conditioning is part of a denture or a reline/rebase, when performed on the same day as the delivery.

  NOTE: An implant is a covered procedure of the Plan only if determined to be Medically Necessary. Claim review for implant services are conducted by licensed Dentists who review the clinical documentation submitted by your treating Dentist. If the dental consultants determine an arch can be restored with a standard prosthesis or restoration, no Benefit will be allowed for the individual implant or implant procedure. Only the second phase of treatment (the prosthodontic phase-placement of the implant crown, bridge, or partial denture) may be subject to the alternate benefit provision of the Plan.

- Implant retained crowns, bridges, and dentures are subject to the alternate benefit provision of the Plan.
- Endosteal, eposteal and transosteal implants—one every 60 months only if determined to be Medically Necessary.

MISCELLANEOUS RESTORATIVE AND PROSTHODONTIC SERVICES

Other restorative and prosthodontic services include:

- Prefabricated crowns – Benefits are provided for stainless steel and resin-based crowns. These crowns are not intended to be used as temporary crowns.
- Recementation of inlays/onlays, crowns, bridges, and post and core.
- Core build up, post and core, and prefabricated post and core are limited to one per tooth every 60 months.
- Crown and bridge repair services.
- Pulp cap – direct and indirect.
- Prosthodontic service adjustments – Benefits will be limited to three times per appliance every 12 months.
- Repairs of inlays, onlays, veneers, crowns, fixed or removable dentures, including replacement or addition of missing or broken teeth or clasp.

MEDICALLY NECESSARY ORTHODONTIC SERVICES

Benefits for Medically Necessary orthodontic services are limited to Subscribers who meet the Policy criteria related to a medical condition including but are not limited to:

- Cleft palate or other congenital craniofacial or dentofacial malformations requiring reconstructive surgical correction in addition to orthodontic services.
- Trauma involving the oral cavity and requiring surgical treatment in addition to orthodontic services.
- Skeletal anomaly involving maxillary and/or mandibular structures.

Benefits for Medically Necessary orthodontic procedures and treatment include examination records, tooth guidance and repositioning (straightening) of the teeth for Subscribers as shown on your ***Schedule of Benefits*** above. Coverage limited to Subscribers with an orthodontic condition meeting Medical Necessity criteria established by the Plan (e.g., severe, dysfunctional malocclusion).

Covered orthodontic services include:

- Diagnostic orthodontic records and radiographs **limited to once every 60 months per Subscriber.**
- Limited, interceptive and comprehensive orthodontic treatment.
- Orthodontic retention, **limited to one appliance every 60 months per Subscriber.**

Special Provisions Regarding Orthodontic Services:

- Orthodontic services are paid over the Course of Treatment. Benefits cease when the Subscriber is no longer covered.
- Orthodontic treatment is started on the date the bands or appliances are inserted.
- Payment for diagnostic services performed in conjunction with orthodontics is applied to the orthodontic Benefit.
- If orthodontic treatment is terminated for any reason before completion, Benefits will cease on the date of termination.
- If the Subscriber's coverage is terminated prior to the completion of the orthodontic treatment plan, the Subscriber is responsible for the remaining balance of treatment costs.
- For services in progress on the Effective Date, Benefits will be reduced based on other benefits paid prior to this coverage beginning.

EXCLUSIONS AND LIMITATIONS

These general "*Exclusions and Limitations"* apply to all services described in this ***Pediatric Dental Services*** section. Dental coverage is limited to services provided by a Dentist, a dental auxiliary, or other Provider (as defined in the ***Definitions*** section) licensed to perform services covered under this dental Addendum.

Important Information About Your Dental Benefits

- **Dental Procedures Which Are Not Medically Necessary**

  Please note that in order to provide you with dental care Benefits at a reasonable cost, this Addendum provides Benefits only for those Covered Services for eligible dental treatment that are determined by the Plan to be Medically Necessary.

  No Benefits will be provided for procedures which are not Medically Necessary. Medically Necessary generally means that a specific procedure provided to you is required for the treatment or management of a dental symptom or condition and that the procedure performed is the most efficient and economical procedure which can safely be provided to you, as determined by the Plan.

  The fact that a Physician or Dentist may prescribe, order, recommend or approve a procedure does not of itself make such a procedure or supply Medically Necessary.

- **Care By More Than One Dentist**

  If you change Dentists in the middle of a particular Course of Treatment, Benefits will be provided as if you had stayed with the same Dentist until your treatment was completed. There will be no duplication of Benefits.

- **Alternate Benefits**

  If more than one Covered Service will treat a dental condition, payment is limited to the least costly service provided it is a professionally accepted, necessary and appropriate treatment, as determined by the Plan. If you or your Dentist requests or you accept a more costly Covered Service, you are responsible for expenses that exceed the amount covered for the least costly service.

  When two or more services are submitted and the services are considered part of the same service, the Plan will pay the most comprehensive service as determined by the Plan.

  When two or more services are submitted on the same day and the services are considered mutually exclusive (one service contradicts the need for the other service), the Plan will pay for the service that represents the final treatment as determined by the Plan.

- **Non-Compliance with Prescribed Care**

  Any additional treatment and resulting liability which is caused by the lack of a Subscriber's cooperation with the Dentist or from non-compliance with prescribed dental care will be the responsibility of the Subscriber.

- **Limitation on Plan's Right to Recoupment/Recovery**

  The Plan will not seek recovery of a claim solely due to a loss of coverage of a patient or ineligibility if, at the time of treatment, the Plan erroneously confirms coverage and eligibility, but had sufficient information available indicating that the patient was no longer covered or was ineligible for coverage.

Exclusions — What Is Not Covered

No Benefits will be provided under this Addendum for:

- Services or supplies not specifically listed as a Covered Service, or when they are related to a non-covered service.
- Amounts which are in excess of the Allowable Charge, as determined by the Plan.
- Dental services for treatment of congenital or developmental malformation, or services performed for cosmetic purposes, including but not limited to bleaching teeth, lack of enamel and grafts to improve aesthetics except as described in the pediatric Medically Necessary orthodontic Benefit as shown in Medically Necessary Orthodontic Services.
- Dental services or appliances for the diagnosis and/or treatment of temporomandibular joint dysfunction and related disorders, unless specifically mentioned in this Addendum or if resulting from accidental injury. Dental services or appliances to increase vertical dimension, unless specifically mentioned in this Addendum.
- Dental services which are performed due to an accidental injury. Injury caused by chewing or biting an object or substance placed in your mouth is not considered an accidental injury.
- Services and supplies 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.
- Services or supplies that do not meet accepted standards of dental practice.
- Experimental, Investigational and/or Unproven services and supplies and all related services and supplies.
- Hospital and ancillary charges.
- Implants and any related services and supplies (other than crowns, bridges and dentures supported by implants) associated with the placement and care of implants.
- Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.
- Services or supplies for which "discounts" or waiver of Deductible or Coinsurance amounts are offered.
- Services rendered by a Dentist related to you by blood or marriage.
- Services or supplies received from someone other than a Dentist, except for those services received from a licensed dental hygienist under the supervision and guidance of a Dentist, where applicable.
- Claims for a service which is for the same service performed on the same date for the same Subscriber.
- Services or supplies received for behavior management or consultation purposes.
- 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 the employer or insurance carrier.

- Any services or supplies to the extent payment has been made under Medicare or to the extent governmental units provide benefits or would have provided benefits if you had applied for and claimed those benefits (some state or federal laws may affect how we apply this exclusion).
- Charges for nutritional or oral hygiene counseling.
- Charges for local, state or territorial taxes on dental services or procedures.
- Charges for the administration of infection control procedures as required by local, state or federal mandates.
- Charges for duplicate, temporary or provisional prosthetic device or other duplicate, temporary or provisional appliances.
- Charges for telephone consultations, email or other electronic consultations, missed appointments, completion of a claim form or forwarding requested records or x-rays.
- Charges for prescription or non-prescription mouthwashes, irrigation mouth rinses, topical solutions, preparations or medicament carriers.
- Charges for personalized restorations, or personalized complete or partial dentures and overdentures, or to employ specialized techniques for dental services rather than professionally accepted, necessary and appropriate treatment; except this exclusion will not apply to the Benefits provided for the Covered Services subject to the Alternate Benefit provision.
- Charges for athletic mouth guards, isolation of tooth with rubber dam, metal copings, mobilization of erupted/malpositioned tooth, precision attachments for partials and/or dentures and stress breakers.
- Any services, treatments or supplies included as Covered Services under other hospital, medical and/or surgical coverage.
- Case presentations or detailed and extensive treatment planning when billed for separately.
- Charges for occlusion analysis, diagnostic casts or occlusal adjustments.
- Orthodontic treatment that is not Medically Necessary.
- Cone beam imaging and cone beam MRI procedures.
- Sealants for teeth other than permanent molars.
- Localized delivery of antimicrobial agents or chemotherapeutic agents.
- Comprehensive periodontal evaluations or problem-focused evaluations if Covered Services are rendered on the same date as any other oral evaluation and by the same Dentist.
- Tests and oral pathology procedures, or for re-evaluations.
- Any radiographs taken related to the diagnosis of Temporomandibular Joint (TMJ) Dysfunction.
- Nutritional, tobacco and oral hygiene counseling.
- Local anesthesia, therapeutic parenteral drugs, or other drugs or medicaments and/or their application.
- Endodontic retreatments provided within 12 months of the initial endodontic therapy by the same Dentist on the same tooth.
- Pulp vitality tests, endodontic endosseous implants, intentional reimplantations, canal preparation, fitting of preformed dowel and post or post removal.
- Endodontic therapy if you discontinue endodontic treatment.
- Surgical services related to a congenital malformation.
- Prophylactic removal of third molars or impacted teeth (asymptomatic, nonpathological), or for complete bony impactions covered by another benefit plan.

- Excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bones; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation, or excision of the temporomandibular joints.
- Bone grafts in conjunction with extractions, apicoectomy or any non-covered service or non-covered implants.
- Guided tissue regeneration, or for biologic materials to aid in tissue regeneration.
- The replacement of a lost, missing or stolen appliance and those for replacement of appliances that have been damaged due to abuse, misuse, or neglect.
- To alter, restore, or correct vertical dimension of occlusion. Such procedures may include, but are not limited to equilibration dentures, crowns, inlays, onlays, bridgework, or other appliances or services used for the purpose of splinting, alter vertical dimension or to restore occlusion or to correct attrition, abrasion, erosion, or abfractions.
- The restoration of occlusion or incisal edges due to bruxism or harmful habits or to correct attrition, abrasion, abfractions or erosion.
- Splinting of teeth, including double retainers for removable partial dentures and fixed bridgework.
- Recementation of an orthodontic appliance by the same Provider who placed the appliance and/or who is responsible for the ongoing care of the Subscriber.
- Replacement or repair of an orthodontic appliance.
- Orthodontic treatment for dental conditions that are primarily cosmetic in nature or when self-esteem is the primary reason for treatment that is not Medically Necessary.

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

EXTENSION OF YOUR DENTAL BENEFITS IN CASE OF TERMINATION

If coverage under your Certificate or under this ***Pediatric Dental Services Addendum*** should terminate, Benefits will continue for any dental Covered Services described in this ***Pediatric Dental Services Addendum,*** as long as the Covered Service began prior to the date your coverage terminated and is completed within 30 days of your termination date. No Benefits will be provided for periodontal treatment after the termination of your Certificate or this Addendum.

PRETREATMENT ESTIMATE OF BENEFITS AND TREATMENT PLAN

If your Dentist recommends a Course of Treatment, your Dentist should prepare a claim form describing the planned treatment (called a "treatment plan"), copies of necessary x-rays, photographs and models and an estimate of the charges prior to your beginning the Course of Treatment. The Plan will review the report and materials, taking into consideration any alternative adequate Course of Treatment, and will notify you and your Dentist of the estimated Benefits which will be provided under this Certificate within 30 days of the date a request is submitted by a dentist. This is an estimate of the Benefits available for the proposed services to be rendered. The Plan's Pretreatment Estimates of Benefits are valid for 180 days, provided all eligibility and Certificate requirements are met. If the approved procedure is not done within that time period, or if the patient's condition changes, you are responsible

for asking the Dentist to submit another request and treatment plan, along with the required current documentation. A new Pretreatment Estimate of Benefits must then be issued by the Plan.

HOW TO FILE A CLAIM

The following provisions are added to the ***Claims Filing Procedures*** section of your Certificate.

- **Filing Dental Claims**

  In order to obtain your dental Benefits under this Addendum, it is necessary for a claim to be filed with the Plan. Usually all you have to do is show your Blue Cross and Blue Shield of Oklahoma Identification Card to your Dentist. They will file you claim for you. Remember, however, it is your responsibility to ensure that the necessary claim information has been provided to the Plan.

  Benefits for a Properly Filed Claim will not be denied for procedures specifically included in the Pretreatment Estimate unless at least one of the following circumstances applies for each procedure denied:

  - Benefit limitations such as annual maximums, Benefit period maximums or lifetime maximums, not applicable at the time of the Pretreatment Estimate, are reached due to utilization after the Pretreatment Estimate was issued;
  - the claim clearly fails to support the Pretreatment Estimate as originally authorized; if after the Pretreatment Estimate was issued, new procedures are provided to the patient or a change in the condition of the patient occurs such that the Pretreatment Estimate procedure would no longer be considered Medically Necessary, based on the prevailing standard of care;
  - if after the Pretreatment Estimate was issued, new procedures or a change in the condition of the patient occurred, such that the procedure for which the Pretreatment Estimate was submitted would, at the time that it was submitted, have required disapproval based on the terms and conditions for coverage under the Plan which was in effect at the time the Pretreatment Estimate was used; or
  - the denial of the dental service contractor was due to one of the following:
    - another payor is responsible for payment,
    - the Dentist has already been paid for the procedures identified on the claim,
    - the claim was submitted fraudulently, or the Pretreatment Estimate was based in whole or material part on erroneous information provided to the Plan by the Dentist, patient, or other person not related to the Plan, or
    - the person receiving the procedure was not eligible to receive the procedure on the date of service and the Plan did not know, and with the exercise of reasonable care could not have known, of their eligibility status.

  If you use an Out-of-Network Dentist and have to file a claim yourself, you should complete and sign the Subscriber/Insured Information of the Attending Dentist's Statement. As soon as treatment has ended, ask your Dentist to complete and sign the Attending Dentist's Statement, and file it with:

  Blue Cross and Blue Shield of Oklahoma
  P.O. Box 23060
  Belleville, IL 62223-0060

  Claims must be filed with the Plan within 180 days following the end of the Benefit Period for which the claim is made. Claims not filed within the required time period will not be eligible for payment. Should you have

any questions about filing claims, call a Customer Service Representative at 1-888-454-5590 between 8:00 a.m. and 6:00 p.m., Monday through Friday.

- **Dental Claim Review Procedures**

  If your claim has been denied in whole or in part, you may have your claim reviewed. The Plan will review its decision in accordance with the following procedure.

  Within 180 days after you receive notice of a denial or partial denial, write to the Plan. The Plan will need to know the reasons why you do not agree with the denial or partial denial.

  Send your request to:

  Blue Cross and Blue Shield of Oklahoma
  P.O. Box 23060
  Belleville, IL 62223-0060

  You may also designate a representative to act for you in the review procedure. 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.

  While the Plan will honor telephone requests for information, such inquiries will not constitute a request for review.

  You and your authorized representative may ask to see relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of a denial or partial denial. The Plan will give you a written decision within 60 days after it receives your request for review.

  If you have any questions about the claim procedures or the review procedure, you may call a Customer Service Representative at 1-888-454-5590 between 8:00 a.m. and 6:00 p.m., Monday through Friday.

  Or, you can write to:

  Blue Cross and Blue Shield of Oklahoma
  P.O. Box 23060
  Belleville, IL 62223-0060

  If you have a claim for Benefits which is denied, in whole or in part, you may file suit in a state or federal court.

Except as amended by this *Pediatric Dental Services Addendum*, all other terms, conditions, limitations and exclusions of the Certificate, to which this Addendum is attached, will remain in full force and effect.

President of Blue Cross and Blue Shield of Oklahoma

BlueCross BlueShield
of Oklahoma

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

PEDIATRIC VISION CARE ADDENDUM

The Certificate of Benefits (Certificate) to which this Addendum is attached and becomes a part is hereby amended as stated below.

This *Pediatric Vision Care Addendum* provides information about coverage for the routine vision care services outlined below, which are specifically excluded under your ***Comprehensive Health Care Services*** Benefits. Services that are covered under your ***Comprehensive Health Care Services*** Benefits are not covered under this *Pediatric Vision Care Addendum.* All provisions in your Certificate for ***Comprehensive Health Care Services*** Benefits apply to this *Pediatric Vision Care Addendum* unless specifically indicated otherwise below.

The Plan has partnered with EyeMed Vision Care, LLC ("EyeMed") to administer the Benefits provided under this *Pediatric Vision Care Addendum*. EyeMed provides customer service and claims administration services to our Subscribers covered under this Addendum and allows our Subscribers access to their extensive network of vision care Providers. For a list of Vision Care Network Providers, please contact a Customer Service Representative at 844-684-2256, or visit the Web site at www.eyemed.com and choose the "Select" network for your search.

This vision care coverage allows Subscribers to select the Provider of their choice, in or out of the Vision Care Provider Network. The Plan has designed these Benefits to deliver quality care, matched with your ***Comprehensive Health Care Services*** Benefits, at the most affordable cost, through network services. You also have the flexibility to visit an Out-of-Network Provider, with a reduction in Benefits.

A. DEFINITIONS

The following definitions are added to the ***Definitions*** section of your Certificate:

- **Provider –** A licensed ophthalmologist or optometrist operating within the scope of his/her license, or a dispensing optician.

  NOTE: If you use the services of any member of the healing arts who is licensed by any state of the United States or its territories to perform services within the scope of his/her license which, if performed by a Physician, optometrist, or optician, would be considered eligible for Benefits under this Addendum, then Benefits will be provided regardless of which healing art performs the service.

- **Vision Care Network Provider –** A Vision Care Network Provider is a Provider who has contracted with the Plan's designated vision care administrator (EyeMed) to provide services under this *Pediatric Vision Care Addendum.* An "Out-of-Network" Provider has not contracted with EyeMed *(even if such Provider is contracted with the Plan to render Covered Services under your* ***Comprehensive Health Care Services*** *Benefits)*.

- **Vision Materials –** Corrective lenses and/or frames or contact lenses.

B. ELIGIBILITY

Children who are covered under the Blue Cross and Blue Shield of Oklahoma Certificate for ***Comprehensive Health Care Services*** Benefits, up to age 19, are eligible for coverage under this *Pediatric Vision Care Addendum.* NOTE: Once coverage is lost under the Individual PPO Contract, all Benefits cease under this *Pediatric Vision Care Addendum.*

C. SCHEDULE OF BENEFITS

The following ***Schedule of Benefits*** is added to your Certificate:

SCHEDULE OF BENEFITS FOR PEDIATRIC VISION CARE SERVICES

Your vision care Benefits are highlighted below. To fully understand all the terms, conditions, limitations, and exclusions which apply to your Benefits, please read your entire Certificate.

Pediatric Vision Care Benefits		
Pediatric Vision Care Services	**In-Network Subscriber Cost**	**Out-of-Network Allowance**[1]
Exam (with dilation as necessary):	No Copayment	$30
Frames: (any available frame at Provider location)		
Provider Designated Frames	No Copayment	$75
Non-Provider Designated Frames	No Copayment up to $150 allowance - you receive 20%[2] off balance over $150	$75

[1]The Plan pays the lesser of the maximum allowance noted or the retail cost. Retail prices vary by location.
[2]Additional discounts are not applicable at certain retail outlets. Call a Customer Service Representative or visit our Web site at www.eyemed.com for additional information.

Pediatric Vision Care Benefits		
Pediatric Vision Care Services	**In-Network Subscriber Cost**	**Out-of-Network Allowance[1]**
Standard Plastic, Glass or Poly Spectacle Lenses:		
Single Vision	No Copayment	$25
Bifocal	No Copayment	$40
Trifocal	No Copayment	$55
Lenticular	No Copayment	$55
Standard Progressive Lens	No Copayment	$55
Lens Options:		
Ultraviolet Treatment	No Copayment	$12
Tint (Solid and Gradient)	No Copayment	$12
Standard Plastic Scratch Coating	No Copayment	$12
Standard Polycarbonate	No Copayment	$32
Photochromic / Transitions Plastic	No Copayment	$57
Contact Lenses: (Contact lens allowance includes materials only)		
Conventional	No Copayment up to $150 allowance - you receive 15%[2] off balance over $150	$150
Disposable	No Copayment up to $150 allowance	$150
Medically Necessary	No Copayment	$210
Note: Additional Benefits over allowance are available from Network Providers except certain retail outlets. Call a Customer Service Representative or visit our Web site at www.eyemed.com for additional information.		
Routine eye exams do not include professional services for contact lens evaluations. Any applicable fees are the responsibility of the Subscriber.		
Frequency:		
Examination	Once every Calendar Year	
Lenses or Contact Lenses	Once every Calendar Year	
Frames	Once every Calendar Year	

[1]The Plan pays the lesser of the maximum allowance noted or the retail cost. Retail prices vary by location.
[2]Additional discounts are not applicable at certain retail outlets. Call a Customer Service Representative or visit our Web site at www.eyemed.com for additional information.

Additional Benefits
Medically Necessary contact lenses: Contact lenses may be determined to be Medically Necessary and appropriate in the treatment of Subscribers affected by certain conditions. In general, contact lenses may be Medically Necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Contact lenses may be determined to be Medically Necessary in the treatment of the following conditions: keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, irregular astigmatism. Medically Necessary contact lenses are dispensed in lieu of other eyewear. Network Providers will obtain the necessary Preauthorization for these services. **Low Vision:** Low vision is a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in low vision care can evaluate and prescribe optical devices and provide training and instruction to maximize the remaining usable vision for our Subscribers with low vision. After Preauthorization, covered low vision services (both In- and Out-of-Network) will include one comprehensive low vision evaluation every 5 years; high-power spectacles, magnifiers and telescopes; and follow-up care to include four visits in any five-year period. Network Providers will obtain the necessary Preauthorization for these services.

D. EXCLUSIONS

In addition to the ***Exclusions*** listed in your Certificate, services or materials connected with or charges arising from the following are not covered:

- Any vision service, treatment or materials not specifically listed as a Covered Service;
- Services and materials not meeting accepted standards of optometric practice;
- Services and materials resulting from your failure to comply with professionally prescribed treatment;
- Telephone consultations;
- Any services that are strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
- Office infection control charges;
- Charges for copies of your records, charts, or any costs associated with forwarding/mailing copies of your records or charts;
- State or territorial taxes on vision services performed;
- Medical and/or surgical treatment of the eye, eyes or supporting structures;
- Orthoptic or vision training; aniseikonic spectacle lenses;
- Any eye or vision examination, or any corrective eyewear required for a Subscriber as a condition of employment; safety eyewear;
- Non-prescription sunglasses;
- Services rendered after the date a Subscriber ceases to be covered under the Certificate, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Subscriber are within 31 days from the date of such order;
- Services or materials provided by any other group benefit plan providing vision care;
- Special lens designs or coatings other than those described in this Addendum;
- Lost or broken lenses, frames, glasses or contact lenses will not be replaced except in the next Benefit frequency when Vision Materials would next become available;
- Non-prescription (Plano) lenses and/or contact lenses;
- Two pairs of eyeglasses in lieu of bifocals;
- Services not performed by licensed personnel;
- Prosthetic devices and services;

- Insurance of contact lenses;
- Professional services you receive from immediate relatives or household members, such as a spouse, parent, child, brother or sister, by blood, marriage or adoption;
- Services covered under your ***Comprehensive Health Care Services*** Benefits.

E. HOW YOUR PEDIATRIC VISION CARE BENEFITS WORK

Under this coverage, you may visit any Vision Care Network Provider and receive Benefits for a vision examination. In order to maximize Benefits for most covered Vision Materials, however, you must purchase them from a Vision Care Network Provider.

For a list of Vision Care Network Providers, please contact a Customer Service Representative at 844-684-2256, or visit the Web site at www.eyemed.com, for the online EyeMed Provider Locator to determine which participating Providers have agreed to the discounted rate (please choose the Select network for your search).

If you obtain eyeglasses or contacts from an Out-of-Network Provider, you must pay the Provider in full and submit a claim for reimbursement (see ***Claims Filing Procedures*** section in your Certificate for more information).

You may receive your eye examination and eyeglasses/contacts on different dates or through different Provider locations, if desired. However, complete eyeglasses must be obtained at one time, from one Provider. Continuity of care will best be maintained when all available services are obtained at one time from one Network Provider and there may be additional professional charges if you seek contact lenses from a Provider other than the one who performed your eye examination.

Fees charged for services other than a covered vision examination or covered Vision Materials, and amounts in excess of those payable under this *Pediatric Vision Care Addendum,* must be paid in full by you to the Provider, whether or not the Provider participates in the vision care network.

Benefits under this *Pediatric Vision Care Addendum* may not be combined with any discount or promotional offering. Allowances are one-time use Benefits; no remaining balances are carried over to be used later.

For information regarding your right to appeal a claim determination, refer to the ***Complaint/Appeal Procedure*** section of your Certificate.

Except as amended by this *Pediatric Vision Care Addendum*, all other terms, conditions, limitations and exclusions of the Certificate, to which this Addendum is attached, will remain in full force and effect.

President of Blue Cross and Blue Shield of Oklahoma

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, 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
400 NE 50th Street
Oklahoma City, OK 73105
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.

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984.

Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
العربية Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員, 請撥電話 號碼 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાર્યક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કૉલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें ।.
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
Diné Navajo	T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídílkidgo, ts'ídá bee ná ahóóti'i' t'áá níik'e níká a'doolwoł dóó bína'ídílkidígíí bee nił h odoonih. Ata'dahalne'ígíí bich'į' hodíílnih kwe'é 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سؤالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با شماره 855-710-6984 تماس حاصل نمایید.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کررہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

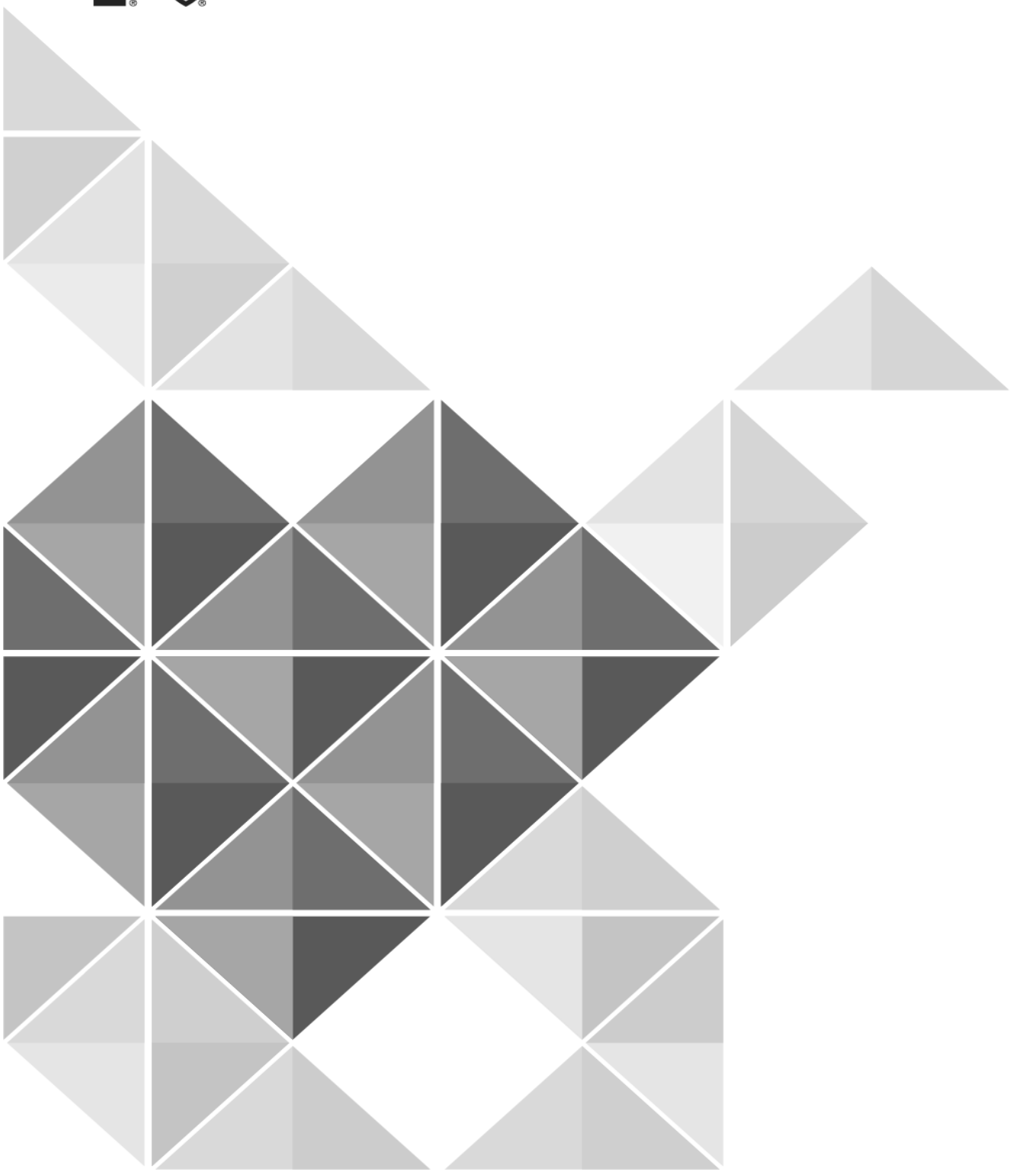
If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator	Phone:	855-664-7270 (voicemail)
300 E. Randolph St.	TTY/TDD:	855-661-6965
35th Floor	Fax:	855-661-6960
Chicago, Illinois 60601	Email:	CivilRightsCoordinator@hcsc.net

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services	Phone:	800-368-1019
200 Independence Avenue SW	TTY/TDD:	800-537-7697
Room 509F, HHH Building 1019	Complaint Portal:	https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Washington, DC 20201	Complaint Forms:	http://www.hhs.gov/ocr/office/file/index.html

CONFIDENTIAL TREATMENT REQUESTED PURSUANT TO FOIA 45 C.F.R. §§ 5.31(d) and (f), AND THE TRADE SECRETS ACT 18 U.S.C. § 1905



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