Your Health Care Benefit Program

HSA Blue
Certificate of Benefits

BlueCross BlueShield of Oklahoma
Experience. Wellness. Everywhere.℠

1215 South Boulder | P.O. Box 3283 | Tulsa, Oklahoma | 74102–3283

70260.0208

HSA Blue
Certificate Insert

Your Benefits under this program are subject to the following provisions:

DEDUCTIBLE*

Member-Only (Single) Coverage	$2,500 per Benefit Period.
Family Coverage	$5,000 per Benefit Period. This Deductible may be met by any one individual or a combination of any two or more covered family members.

OUT-OF-POCKET LIMIT

Member-Only (Single) Coverage	$3,000 per Benefit Period.
Family Coverage	$6,000 per Benefit Period. The Out-of-Pocket Limit may be met by any one individual or a combination of any two or more covered family members.

Refer to this Certificate for additional provisions applicable to your coverage.

KEEP THIS PAGE WITH YOUR CERTIFICATE FOR FUTURE REFERENCE.

* *Deductible and Out-of-Pocket Limits are subject to change in accordance with cost-of-living adjustments imposed by IRC regulations for Health Savings Accounts and high deductible health plans.*

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Certificate

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

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

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

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

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

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

President of Blue Cross and Blue Shield of Oklahoma

Your Subscriber Identification Number: _____

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

Introduction

Your HSA Blue coverage is designed to be a "high deductible health plan" as described in the Internal Revenue Code (IRC) provisions governing Health Savings Accounts (HSAs). If you are eligible for the tax treatment of Health Savings Account (HSA) contributions and distributions (in accordance with IRC regulations), you may elect to establish and maintain an HSA to cover "qualified medical expenses" not covered under this Certificate.

If you elect to take full advantage of the HSA Blue program, you will need to establish a Health Savings Account (HSA) at a bank, insurance company, or other entity specifically approved by the Internal Revenue Service (IRS) as an HSA trustee. When you enroll under this HSA Blue program, you will be given information to help you establish a Health Savings Account regarding your Group's HSA program. You may choose any financial institution you wish to establish your HSA. Please read your account agreement information carefully to be advised of eligibility and other HSA requirements. Funds in the HSA may be used to help pay your Deductible, Coinsurance or other qualified medical expenses not covered under your HSA Blue coverage.

To be eligible to establish and maintain a Health Savings Account, you must meet the requirements in the regulations established by the Internal Revenue Service. In order to participate in a Health Savings Account:

- You cannot be claimed as a dependent under another person's income tax return; and
- You cannot be covered by a health plan, other than a qualifying high deductible health plan, which provides any of the same benefits as this HSA Blue plan.

To qualify under the IRC, your coverage must impose a specified minimum annual Deductible and a maximum Out–of–Pocket Limit. These amounts may be adjusted by the United States Treasury and the Internal Revenue Service to reflect cost–of–living increases. If these cost–of–living adjustments result in a change to your Deductible or Out–of–Pocket Limit under this coverage, you will receive written notice from the Plan.

You are solely responsible for making sure your HSA arrangement complies with the Internal Revenue Code. Blue Cross and Blue Shield of Oklahoma assumes no responsibility or liability in the event the Internal Revenue Service or any other regulatory or enforcement agency finds that you have failed to comply with these requirements.

Keep in mind that Health Savings Accounts and high deductible health plans are subject to rules set out in the IRC and Internal Revenue Service regulations, and can be affected by changes in the IRC and regulations and by any regulatory or judicial interpretations. You are strongly encouraged to seek the advice of a qualified tax counselor before establishing and using an HSA, and to help resolve any questions you might have about the appropriate use of the account after it is established.

Important Information

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

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

THE BLUECHOICE PPO PROVIDER NETWORK

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

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

HOW YOUR HSA BLUE COVERAGE WORKS

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

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

In contrast, when care is received from a Physician who is not a member of the BlueChoice PPO Provider network, a *higher* Coinsurance and Out–of–Pocket Limit will apply to most Covered Serv ices.

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

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

HSA BLUE BROCHURE

As a participant in the Health Savings Account (HSA) program, you will receive additional materials describing how the "Health Savings Account" HSA works with this HSA Blue coverage.

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

Selecting a Provider

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

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

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

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

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

The BlueCard PPO 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 PPO Physician or Hospital outside the state of Oklahoma and to receive the advantages of PPO benefits and savings.

- **Finding a PPO Physician or Hospital**

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

- **Available Care Coast to Coast**

  Show your Identification Card to any Blue Cross and Blue Shield PPO Physician or Hospital across the USA. The PPO Physicians and Hospitals can verify your membership eligibility and coverage with Blue Cross and Blue Shield of Oklahoma. When you visit a PPO Physician or Hospital, you should have no claim forms to file and no billing hassles.

- **Remember to Always Carry the BlueCard**

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

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

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

How The BlueCard PPO 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 participating Physicians and Hospitals, or visit the BlueCard Web site at http://www.bluecares.com.
- You are responsible for Precertification from Blue Cross and Blue Shield of Oklahoma.
- Visit the PPO participating Physician or Hospital and present your Identification Card that has the "PPO in a suitcase" logo.
- The Physician or Hospital verifies your membership and coverage information.
- After you receive medical attention, your claim is electronically routed to Blue Cross and Blue Shield of Oklahoma, which processes it and sends you a detailed Explanation of Benefits. You're only responsible for meeting your Deductible and/or Coinsurance payments, if any.
- All PPO participating Physicians and Hospitals are paid directly, relieving you of any hassle and worry.

Your Prescription Drug Program

Blue Cross and Blue Shield of Oklahoma has contracted with a network of Participating Pharmacies to help hold the line on the increasing costs of Prescription Drugs.

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 will receive a discounted price for your prescriptions and your claims are filed automatically!
- Blue Cross and Blue Shield of Oklahoma will process your claims, subtract any Deductible and/or Coinsurance amounts which apply to your covered prescriptions, and forward the balance directly to you.

In order to receive the highest level of Benefits for your prescription charges, *your prescriptions must be filled at a Participating Pharmacy.* **Your coverage under this program is subject to a reduction in Benefits if your prescriptions are filled at a Pharmacy which is not a member of the Participating Pharmacy network.**

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 the Contract. And, because your pharmacist will not be able to submit your claim electronically, he/she will not be able to apply the discount for your prescriptions.

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

Medical Necessity Limitation

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

This program provides Benefits for Covered Services that are Medically Necessary. **"Medically Necessary" is defined as services or supplies provided by a Provider that the Plan determines are:**

- **appropriate for symptoms and diagnosis to treat your condition, illness, disease or injury; and**
- **in line with standards of good medical practice; and**
- **not primarily for your or your Provider's convenience; and**
- **the most appropriate supply or level of service which can be safely provided to you. When applied to the care of an Inpatient, this means that your condition or the services you need require acute care as a bed patient and you cannot receive safe or adequate care as an Outpatient.**

Precertification

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

For an Inpatient facility stay, *you must request Precertification from the Plan* ***before*** *your scheduled admission*. The Plan will consult with your Physician, Hospital, or other facility to determine if Inpatient level of care is required for your illness or injury. The Plan may decide that the treatment you need could be provided just as effectively in a less expensive setting (such as the Outpatient department of the Hospital, an Ambulatory Surgical Facility, or the Physician's office). If the Plan determines that your treatment does not require Inpatient care, you and your Provider will be notified of that decision. **If you proceed with an Inpatient stay without the Plan's approval, or if you do not ask the Plan for Precertification, your Benefits under this Certificate will be reduced by $500 for that admission, provided the Plan determines that Benefits are payable upon receipt of a claim.** This reduction applies *in addition to* any Benefit reduction associated with your use of an Out–of–Network Provider.

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

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

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

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

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

- **Precertification Requests Involving Urgent Care**

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

— could seriously jeopardize the life or health of the 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 Precertification request.

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

— the Plan's receipt of the specified information; or

— the end of the 48–hour period you were given to provide the specified information.

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

- **Precertification Requests Involving Emergency Care**

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

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

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

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

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

Concurrent Review and Case Management

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

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

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

PRESCRIPTION DRUG PRECERTIFICATION PROCESS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

If the drug you received is one which requires prior approval, the Plan will review the claim to determine if Precertification approval would have been given. If so, Benefits will be processed in accordance with your Prescription Drug coverage. If the Precertification 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 Precertification/Step Therapy program, please visit our Web site at www.bcbsok.com. If you have questions about Step Therapy, or any other aspects of the Precertification process, please call 1–800–94 BLUES (1–800–942–5837) for assistance.

ALLOWABLE CHARGE

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

- BlueChoice PPO and BlueCard PPO Providers have agreed to hold the line on health care costs by providing special prices for our Subscribers. These Providers will accept this negotiated price (called the **"Allowable Charge"**) as payment for Covered Services. This means that, if a network Provider bills you more than the Allowable Charge for Covered Services, ***you are not responsible for the difference*.**
- Blue Cross and Blue Shield of Oklahoma will calculate your Benefits based on this "Allowable Charge". We will deduct any charges for services which aren't eligible under your coverage, then subtract your Copayment, Deductible and/or Coinsurance amounts which may be applicable to your Covered Services. We will then determine your Benefits under this Certificate, and direct any payment to your network Provider.

REMEMBER ...

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

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

- If you use an Oklahoma Out–of–Network Provider, the Plan will determine the Allowable Charge for your out–of–network claims **based upon the amount the Plan would have reimbursed an Oklahoma BlueChoice PPO Provider for the same service**. You will be responsible for the following:

  — Charges for any services which are not covered under your Group Health Plan.

  — Any Deductible or Coinsurance amounts that are applicable to your coverage *(including the higher Coinsurance amounts which apply to Out–of–Network Provider services)*.

  — The difference, if any, between your Provider's "billed charges" and the "Allowable Charge" which a BlueChoice PPO Provider would have accepted for the same services.

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

  — Charges for any services which are not covered under your Group Health Plan.

  — Any Deductible or Coinsurance amounts that are applicable to your coverage *(including the higher Coinsurance amounts which apply to Out–of–Network Provider services)*.

  — The difference, if any, between your Provider's "billed charges" and the "Allowable Charge" determined by the Host Plan.

- In instances where the claim is not filed with the Host Plan, the Allowable Charge for your out–of–network claims will be ***based upon what the Plan would have reimbursed a BlueChoice PPO Provider for the same service.*** You will be responsible for the following:

  — Charges for any services which are not covered under your Group Health Plan.

  — Any Deductible or Coinsurance amounts that are applicable to your coverage (*including the higher Coinsurance amounts which apply to Out–of–Network Provider services*).

  — The difference, if any, between your Provider's "billed charges" and the "Allowable Charge" which a BlueChoice PPO Provider would have accepted for the same services.

- In certain instances, your services may be rendered by a Provider who has a Participating Provider Agreement (other than a BlueChoice PPO Participating Agreement) with Blue Cross and Blue Shield of Oklahoma. These Providers (called BlueTraditional Providers) have agreed to charge Plan Subscribers no more than a "Maximum Reimbursement Allowance" for Covered Services. If you receive Covered Services from a BlueTraditional Provider, you will be responsible for the following:

  — Charges for any services which are not covered under your Group Health Plan.

  — Any Deductible or Coinsurance amounts that are applicable to your coverage (*including the higher Coinsurance amounts which apply to Out–of–Network Provider services*).

  — Any amounts over the "Allowable Charge" up to but not exceeding the "Maximum Reimbursement Allowance" specified in their Participating Provider Agreement.

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

SPECIAL NOTICES

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

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

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

Identification Card

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

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

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

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

Designating an Authorized Representative

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

Questions

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

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

Or you can write:

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

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

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

Eligibility, Enrollment, Changes & Termination

This section tells:

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

WHO IS AN ELIGIBLE PERSON

Unless otherwise specified in the Group Contract, you are an Eligible Person if you are an Employee who works on a full–time basis with a normal work week of 24 or more hours. If you work on a part–time, temporary or substitute basis, you are not considered an Eligible Person.

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

WHO IS AN ELIGIBLE DEPENDENT

An Eligible Dependent is defined as:

- your spouse.
- your unmarried child, including a newborn child, adopted child, stepchild, or other child for whom you or your spouse is legally responsible.
  - — Unmarried Dependent children are eligible for coverage until January 1 of the year following their 19th birthday.
  - — Unmarried Dependent children who are enrolled as Full–Time Students are eligible for coverage until their 23rd birthday.
  - — Unmarried Dependent children who are medically certified as disabled and dependent upon you or your spouse are eligible for coverage regardless of age.

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

HOW TO ENROLL

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

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

IMPORTANT:

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

INITIAL ENROLLMENT PERIOD

- **Initial Group Enrollment**

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

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

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

- **Initial Enrollment of New Dependents**

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

  — **Newborn Children**

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

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

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

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

IMPORTANT:

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

— **Adopted Children**

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

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

Special Enrollment Periods

Your Group Health Plan includes Special Enrollment Periods during which individuals who previously declined coverage are allowed to Enroll (without having to wait until the Group's next regular Open Enrollment Period). A Special Enrollment Period can occur if a person with other health coverage loses that coverage or if a person becomes a Dependent through marriage, birth, adoption, or Placement for Adoption. A person who Enrolls during a Special Enrollment Period is not treated as a Late Enrollee, and the Plan may not impose a Preexisting Condition Exclusion period longer than 12 months.

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

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

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

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

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

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

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

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

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

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

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

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

- **Special Enrollment For New Dependents**

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

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

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

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

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

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

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

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

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

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

Open Enrollment Period

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

Individuals who Enroll during an Open Enrollment Period will be considered Late Enrollees under the Contract and will be subject to an 18–month Preexisting Condition Exclusion period. However, the 18–month Preexisting Condition Exclusion period will be reduced by the following:

- the days of prior Creditable Coverage in effect before your and/or your Dependent's application was received by the Plan; and
- the period of time between the Contract Date Anniversary and the date your and/or your Dependent's initial application for coverage was received by the Plan (for individuals who applied for coverage prior to the Open Enrollment Period).

Qualified Court Orders for Medical Coverage for Dependent Children

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

The order must include specific information such as:

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

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

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

Delayed Effective Date

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

This provision will not apply if you were:

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

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

Deleting a Dependent

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

Transfers From Alternate Coverage Options

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

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

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

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

When Eligibility Continues

- TOTAL DISABILITY

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

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

- OTHER

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

COBRA Continuation Coverage

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

- **Eligibility for Continuation Coverage**

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

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

  — your divorce or legal separation; or

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

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

- **Election of Continuation Coverage**

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

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

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

- **COBRA Continuation Coverage Period**

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

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

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

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

    ○ the ineligibility of a Dependent child;

  provided the premiums are paid for the coverage as required.

- **Disability Extension**

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

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

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

- **Multiple Qualifying Events**

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

- **Special TAA/ATAA Election Period**

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

When Coverage Under This Certificate Ends

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

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

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

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

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

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

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

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

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

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

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

What We Will Pay for After Your Coverage Ends

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

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

  — the duration of the Hospital confinement; or

  — 90 days following termination of coverage; or

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

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

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

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

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

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

  — the payment of maximum Benefits; or

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

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

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

Conversion Privilege After Termination of Group Coverage

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

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

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

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

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

A conversion contract will not be available if you are:

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

When You Turn Age 65

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

Your coverage may include:

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

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

When You Retire

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

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

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

IMPORTANT:

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

Certificates of Coverage

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

- **Qualified Beneficiaries Upon a Qualifying Event**

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

- **Other Individuals When Coverage Ceases**

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

- **Qualified Beneficiaries When COBRA Ceases**

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

- **Any Individual Upon Request**

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

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

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

Schedule of Benefits
Comprehensive Health Care Services

This section shows how much we pay for Covered Services described in the ***Comprehensive Health Care Services*** section that follows**. Please note that services must be Medically Necessary in order to be covered under this program.**

BENEFIT PERIOD	Calendar Year
DEDUCTIBLE*	The Deductible applies to all Covered Services received by a Subscriber during the Benefit Period, except: • Preventive Care Services for Subscribers age 19 or older (limited to $300 per Benefit Period); • Annual prostate cancer screening (limited to $65 per screening); • Annual routine gynecological/obstetrical examination and Pap smear; • Covered childhood immunizations for Subscribers under age 19; • Routine Low–Dose Mammography (limited to $115 per screening).
Member–Only (Single) Coverage	The amount specified in the insert in the front of this Certificate.
Family Coverage	If your coverage includes one or more Dependents, then your family must satisfy the Deductible amount specified in the insert in the front of this Certifiate before Benefits are provided during the Benefit Period. This Deductible may be met by any one individual or a combination of any two or more covered family members. If you change from Member–Only to Family Coverage during a Benefit Period, the family Deductible must be met before Benefits will be provided under this Certificate.
OUT–OF–POCKET LIMIT*	
Member–Only (Single) Coverage	Once a Member with Member–Only Coverage has paid the dollar amount specified in the insert in the front of this Certificate in Deductible and Coinsurance for Covered Services during a Benefit Period, the amount of Allowable Charges covered by the Plan will increase to 100% during the remainder of the Benefit Period.

**Deductible and Out–of–Pocket Limits are subject to change in accordance with cost–of–living adjustments imposed by IRC regulations for Health Savings Accounts and high deductible health plans.*

Family Coverage

If your coverage includes one or more of your Dependents, the Out–of–Pocket Limit will be met when any one or more covered family members have paid Deductible and Coinsurance totaling the dollar amount specified in the insert in the front of this Certificate.

Once the family Out–of–Pocket Limit has been reached, the amount of Allowable Charges covered by the Plan on behalf of any covered family member will increase to 100% during the remainder of the Benefit Period.

If you change from Member–Only to Family Coverage during a Benefit Period, the family Out–of–Pocket Limit will apply to you and any covered family members, even if you had previously satisfied the Out–of–Pocket Limit under Member–Only Coverage.

MAXIMUM

$2,000,000 per lifetime per Subscriber, including any other limitations specifically stated in this Certificate.

BENEFIT PERCENTAGE AMOUNT

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

COVERED SERVICES (Subject to the *Comprehensive Health Care Services* section which follows)	BENEFIT PERCENTAGE AMOUNT: BlueChoice PPO & BlueCard PPO Provider Services	Out–of–Network Provider Services
HOSPITAL SERVICES	80%	60%
SURGICAL/MEDICAL SERVICES		
Covered Childhood Immunizations (Limited to Subscribers under age 19)	100%	100%
Preventive Care Services (Limited to $300 per Benefit Period for Subscribers age 19 or older)	100%	100%
Annual Routine Gynecological/Obstetrical Examination and Pap Smear	100%	100%
All Other Covered Surgical/Medical Services	80%	60%
OUTPATIENT DIAGNOSTIC SERVICES		
Routine Low–Dose Mammography (Limited to $115 per screening)	100%	100%
All Other Covered Diagnostic Services	80%	60%
OUTPATIENT THERAPY SERVICES	80%	60%
MATERNITY SERVICES	80%	60%
MASTECTOMY AND RECONSTRUCTIVE SURGICAL SERVICES	80%	60%
HUMAN ORGAN, TISSUE AND BONE MARROW TRANSPLANT SERVICES	80%	60%
AMBULATORY SURGICAL FACILITY SERVICES	80%	60%
PSYCHIATRIC CARE SERVICES	50%	50%
AMBULANCE SERVICES	80%	60%
PRIVATE DUTY NURSING SERVICES	80%	60%
REHABILITATION CARE	80%	60%
SKILLED NURSING FACILITY SERVICES	80%	60%
HOME HEALTH CARE SERVICES	80%	60%

COVERED SERVICES (Subject to the *Comprehensive Health Care Services* section which follows)	BENEFIT PERCENTAGE AMOUNT: BlueChoice PPO & BlueCard PPO Provider Services	Out–of–Network Provider Services
HOSPICE SERVICES	80%	60%
OUTPATIENT PRESCRIPTION DRUGS AND RELATED SERVICES*	80%	60%
ALL OTHER COVERED SERVICES	80%	60%

**Applies to prescriptions filled at a Participating Pharmacy, regardless of prescribing Physician's status as a BlueChoice PPO, BlueCard PPO or Out–of–Network Provider.*

Comprehensive Health Care Services

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

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

- **Ancillary Services**

  — Operating, delivery and treatment rooms;

  — Prescribed drugs;

  — Whole blood, blood processing and administration;

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

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

  — Oxygen;

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

  — Diagnostic Services;

  — Therapy Services.

  Benefits for Speech Therapy are limited to Inpatient services only.

- **Emergency Accident Care**

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

- **Emergency Medical Care**

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

- **Surgery**

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

- **Routine Nursery Care**

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

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

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

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

  Benefits are not provided for Routine Nursery Care for an infant born to a Dependent child.

SURGICAL/MEDICAL SERVICES

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

- **Surgery**

  Payment includes visits before and after Surgery.

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

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

    ○ the primary procedure; plus

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

  — Sterilization, regardless of Medical Necessity.

- **Assistant Surgeon**

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

- **Anesthesia**

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

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

- **Inpatient Medical Services**

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

  — Inpatient Medical Care Visits

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

  — Intensive Medical Care

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

  — Concurrent Care

  ○ Care for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery.

  ○ If the nature of the illness or injury requires, care by two or more Physicians during one Hospital stay.

  — Consultation

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

  — Newborn Well Baby Care

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

- **Outpatient Medical Services**

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

  — Emergency Accident Care

  Treatment of accidental bodily injuries.

  — Emergency Medical Care

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

  — Home, Office, and Other Outpatient Visits

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

  — Preventive Care Services

  Services performed by a Provider as "routine" or "screening" services, **limited to $300 per Benefit Period for Subscribers age 19 or older**. Routine or screening examinations which meet the guidelines for mandated Benefits, established by Oklahoma state law, shall not be included as Preventive Care Services, but shall be subject to the limitations specified elsewhere in this Certificate.

  Unless specifically provided by Oklahoma state law, the following services are not included:

  ○ Hearing or vision screening examinations;

  ○ Medical supplies or equipment;

  ○ Routine foot care.

— Routine Gynecological/Obstetrical Examination and Pap Smear

Routine gynecological/obstetrical examination and Pap smear performed in the Physician's office, **limited to once each Benefit Period.**

— 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.

— Prostate Cancer Screening

Annual screening for the early detection of prostate cancer in male Subscribers, including a prostate–specific antigen blood test and a digital rectal examination. **Benefits are limited to one screening exam per Benefit Period and shall not exceed $65 per screening.**

— Colorectal Cancer Screening

Colorectal cancer examinations and laboratory tests for cancer screening for any nonsymptomatic Subscriber, in accordance with standard, accepted published medical practice guidelines.

— Immunizations, limited to:

- Diphtheria, tetanus, and pertussis (whooping cough) vaccine (DTaP);
- Tetanus vaccine;
- Poliomyelitis vaccine;
- Measles virus vaccine;
- Mumps virus vaccine;
- German measles (rubella) vaccine;
- Measles, mumps, and rubella vaccine (MMR);
- Varicella (chicken pox) vaccine;
- Pneumonia vaccine;
- Pneumococcal vaccine;
- Haemophilus influenzae type b (Hib);
- Rotavirus vaccine, **limited to Subscribers under age 19**;
- Human papillovirus vaccine (HPV), **limited to Subscribers under age 19;**
- Hepatitis A and hepatitis B vaccine, **limited to Subscribers under age 19;**
- Meningococcal vaccine, **limited to Subscribers under age 19**;
- Any other immunization required for children by the Oklahoma State Board of Health.

— Child Health Supervision Services

The periodic review of a child's physical and emotional status by a Physician or other Provider pursuant to a Physician's supervision, including a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests in keeping with prevailing medical standards.

Child Health Supervision Services must be rendered during a periodic review, provided by or under the supervision of a single Physician during the course of one visit.

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

— Audiological Services

Audiological services and hearing aids, limited to:

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

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

— Bone Density Testing

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

Outpatient Diagnostic Services

- Radiology, Ultrasound and Nuclear Medicine

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

  — one screening examination every five years for female Subscribers age 35 through 39; and

  — one *annual* screening examination for female Subscribers age 40 or older.

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

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

Outpatient Therapy Services

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

Benefits for Outpatient Physical Therapy and Outpatient Occupational Therapy are limited to a combined maximum of 25 visits per Benefit Period per Subscriber.

MATERNITY SERVICES

- Hospital Services and Surgical/Medical Services from a Provider (not including the services of midwives) to a Member or the Member's covered spouse for:
  - — Normal Pregnancy

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

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

    At the mother's discretion, visits may occur at the facility of the Provider instead of the home.
- Inpatient care shall include, at a minimum:
  - — physical assessment of the mother and newborn infant;
  - — parent education regarding childhood immunizations;
  - — training or assistance with breast or bottle feeding; and

— performance of any Medically Necessary and appropriate clinical tests.

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

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

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

    ○ the gestational age, birth weight and clinical condition of the newborn infant;

    ○ the demonstrated ability of the mother to care for the newborn infant postdischarge; and

    ○ the availability of postdischarge follow–up to verify the condition of the newborn infant in the first 48 hours after delivery; and

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

    ○ physical assessment of the mother and newborn infant;

    ○ parent education regarding childhood immunizations;

    ○ training or assistance with breast or bottle feeding; and

    ○ performance of any Medically Necessary and appropriate clinical tests.

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

Maternity Services for Dependent children are not covered, except for complications of pregnancy.

MASTECTOMY AND RECONSTRUCTIVE SURGICAL SERVICES

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

- Inpatient Hospital Services for:

  — not less than 48 hours of Inpatient care following a mastectomy; and

  — not less than 24 hours of Inpatient care following a lymph node dissection for the treatment of breast cancer.

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

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

  — reconstruction of the breast on which the mastectomy has been performed;

  — Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

— prostheses and physical complications at all stages of mastectomy, including lymphedema.

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

HUMAN ORGAN, TISSUE AND BONE MARROW TRANSPLANT SERVICES

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

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

- **DEFINITIONS**

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

— **Precertification**

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

— **Procurement Services**

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

- **TRANSPLANT SERVICES**

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

— Musculoskeletal transplants;

— Parathyroid transplants;

— Cornea transplants;

— Heart–valve transplants;

— Kidney transplants;

— Heart transplants;

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

— Liver transplants;

— Intestinal transplants;

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

— Pancreas transplants;

— Islet cell transplants; and

— Bone Marrow Transplants.

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

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

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

  ○ Adrenal to brain transplants.

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

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

- **DONOR BENEFITS**

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

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

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

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

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

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

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

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

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

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

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

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

Ambulatory Surgical Facility Services

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

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

Psychiatric Care Services

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

- Inpatient Facility Services

  Covered Inpatient Hospital Services provided by a Hospital or other Provider.

- Inpatient Medical Services

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

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

  — Individual Psychotherapy;

  — Group Psychotherapy;

  — Psychological Testing; and

  — Convulsive Therapy Treatment.

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

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

- Outpatient Psychiatric Care Services

  — Facility and Medical Services

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

— Day/Night Psychiatric Care Services

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

- Drug Abuse and Alcoholism

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

Your Benefits for Psychiatric Care Services will not exceed:

- **30 days' Inpatient Psychiatric Care Services per Benefit Period per Subscriber.**
- **20 visits per Benefit Period per Subscriber for Outpatient Psychiatric Care Services.**

Ambulance Services

- Medically Necessary transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured:
  - — From your home to a Hospital;
  - — From the scene of an accident or medical emergency to a Hospital;
  - — Between Hospitals;
  - — Between a Hospital and a Skilled Nursing Facility; or
  - — From the Hospital to your home.
- Ambulance Services means local transportation to the closest facility that can provide Covered Services appropriate for your condition. If none, you are covered for trips to the closest such facility outside your local area.

Private Duty Nursing Services

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

Benefits for Private Duty Nursing Services are limited to $6,000 per Benefit Period per Subscriber.

Rehabilitation Care

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

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

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

Skilled Nursing Facility Services

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

Skilled Nursing Facility Services are limited to 30 days of Inpatient care per Benefit Period per Subscriber.

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

No Benefits are payable:

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

Home Health Care Services

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

- Medical and surgical supplies;
- Prescribed drugs;
- Oxygen and its administration;
- **Up to 30 visits per Benefit Period per Subscriber, limited to the following:**
  - — Professional services of an RN, LPN, or LVN;
  - — Medical social service consultations;
  - — Health aide services while you are receiving covered nursing or Therapy Services;
  - — Services of a licensed registered dietician or licensed certified nutritionist, when authorized by the patient's supervising Physician and when Medically Necessary as part of diabetes self–management training.

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

We do not pay Home Health Care Benefits for:

- Dietician services, except as specified for diabetes self–management training;
- Homemaker services;
- Maintenance therapy;
- Physical Therapy, Speech Therapy, or Occupational Therapy;
- Durable Medical Equipment;
- Food or home–delivered meals;
- Intravenous drug, fluid, or nutritional therapy, **except when you have received Precertification 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.

Benefits for Hospice Services are limited to $6,000 per Benefit Period per Subscriber.

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

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.

Outpatient Prescription Drugs and Related Services

Outpatient Prescription Drugs and related services, limited to the following:

- Prescription Drugs dispensed for a Subscriber's Outpatient use, when recommended by and while under the care of a Physician or other Provider;
- Injectable insulin and insulin products, but only when dispensed in accordance with a written prescription by a licensed Physician;
- Oral contraceptives, when prescribed by a licensed Physician;
- Prescription Drugs prescribed for treatment of attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD) for Subscribers age 19 and under, subject to the Plan's guidelines for Precertification; and
- Self–injectable Prescription Drugs, when dispensed by a Pharmacy. Self–injectable drugs purchased from a Physician and administered in his/her office are not covered.

Benefits will not be provided for Prescription Drugs prescribed and used for cosmetic purposes.

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

- **Up to a 34–day supply for "non–maintenance" drugs; or**
- **Up to a 90–day supply for nitroglycerin, natural thyroid products, and other drugs designated by the Plan as "maintenance" legend Prescription Drugs.**

Diabetes Equipment, Supplies and Self–Management Services

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

— Syringes;

— Insulin pumps and appurtenances thereto;

— Insulin infusion devices;

— Oral agents for controlling blood sugar;

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

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

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

  — Visits Medically Necessary upon the diagnosis of diabetes;

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

  — Visits when reeducation or refresher training is Medically Necessary.

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

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

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

DURABLE MEDICAL EQUIPMENT

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

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

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

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

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

Benefits for Durable Medical Equipment will not exceed $5,000 per Benefit Period per Subscriber.

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 due to changes in the size of the limb being augmented.

Benefits for prosthetic appliances will not exceed $10,000 per Benefit Period per Subscriber.

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 due to changes in the size of the body part being supported.**

Benefits will be provided for the following orthotic devices:

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

Not covered are:

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

Benefits for orthotic devices will not exceed $2,500 per Benefit Period per Subscriber.

Wigs or Other Scalp Prostheses

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

Benefits are limited to $150 per Benefit Period per Subscriber.

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. It also explains the Preexisting Condition provisions in your coverage.

WHAT IS NOT COVERED

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

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

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

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

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

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

- Received from a member of your immediate family.

- Received before your Effective Date.

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

- Received after your coverage stops.

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

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

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

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

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

- For reverse sterilization.

- For contraceptive medications or devices which are sold without a Physician's prescription (including condoms; contraceptive foam, sponges, or cream; or other spermicides).

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

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

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

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

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

— severely disabled; or

— eight years of age or under;

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

- For eyeglasses, contact lenses or examinations for prescribing or fitting them, except for aphakic patients (including lenses required after cataract Surgery) and soft lenses or sclera shells to treat disease or injury. Vision examinations not related to the prescription or fitting of lenses will be a Covered Service only when performed in connection with the diagnosis or treatment of disease or injury. Eye refractions are not covered in any event.

- For eye Surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).

- For hearing aids, tinnitus maskers, or examinations for prescribing or fitting them, except as specified for Subscribers up to age 18. Hearing examinations not related to the prescription or fitting of hearing aids will be a Covered Service only when performed in connection with the diagnosis or treatment of disease or injury.

- For Speech Therapy and any related diagnostic testing, except as provided by a Hospital or rehabilitation facility as part of a covered Inpatient stay.

- For transsexual Surgery or any treatment leading to or in connection with transsexual Surgery.

- For diagnosis, treatment or medications for infertility and fertilization procedures. Examples include any form of: artificial insemination; ovulation induction procedures; in vitro fertilization; embryo transfer; or any other procedures, supplies or medications which in any way are intended to augment or enhance your reproductive ability.

- For treatment of sexual problems not caused by organic disease.

- For treatment of obesity, including morbid obesity, regardless of the patient's history or diagnosis, including but not limited to the following: weight reduction or dietary control programs; surgical procedures; prescription or nonprescription drugs or medications such as vitamins (whether to be taken orally or by injection), minerals, appetite suppressants, or nutritional supplements; and any complications resulting from weight loss treatments or procedures.

- For compounded medications. For purposes of this exclusion, "compounded medications" are substances made by mixing, reconstituting or other such acts, not in accordance with directions contained in Food and Drug Administration (FDA) approved labeling provided by the product's manufacturer and other FDA–approved manufacturer directions consistent with that labeling.

- For Prescription Drugs prescribed and used for cosmetic purposes.

- For or related to acupuncture, whether for medical or anesthesia purposes.

- For conditions related to autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems, mental retardation, or for Inpatient confinement for environmental change. This exclusion ***shall not*** apply to the following Medically Necessary services:

  — Physicians' services (except for neuropsychological testing) related to the diagnosis and treatment of attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD) for Subscribers age 19 and under; or

  — Prescription Drug therapy (provided this Certificate includes Benefits for Outpatient Prescription Drugs) for treatment of ADD/ADHD in Subscribers age 19 and under.

- For family or marital counseling.
- For hippotherapy, equine assisted learning, or other therapeutic riding programs.
- For which the Provider of service customarily makes no direct charge to a Subscriber.
- Received from a Skilled Nursing Facility, Home Health Care Agency, Hospice, or rehabilitation facility which is not a Plan–approved Provider.
- For treatment of temporomandibular joint dysfunction, including but not limited to diagnostic procedures, splints, orthodontic/orthopedic appliances, restorations necessary to increase vertical dimension or to restore or maintain functional or centric occlusion, alteration of teeth or jaws, Physical Therapy, and medication and behavioral modification related to conditions of temporomandibular joint syndrome or any other conditions involving the jaw joint, adjacent muscles or nerves, regardless of cause or diagnosis.
- For or related to transplantation of donor organs, tissues or bone marrow, except as specified under ***"Human Organ, Tissue and Bone Marrow Transplant Services"***.
- For Physician standby services.
- For Continuous Passive Motion (CPM) devices used in treatment of the shoulder or other joints, except for up to 21 days postoperatively for the following surgical procedures: total knee arthroplasty, anterior cruciate ligament reconstruction, or open reduction and internal fixation of tibial plateau for distal femur fractures involving the knee joint.
- For ductal lavage of the mammary ducts.
- For extracorporeal shock wave treatment, also known as orthotripsy, using either a high– or low–dose protocol, for treatment of plantar fasciitis and all other musculoskeletal conditions.
- For orthoptic training.
- For thermal capsulorraphy as a treatment of joint instability, including but not limited to instability of shoulders, knees and elbows.
- For transcutaneous electrical nerve stimulator (TENS).
- For drug and alcohol treatment that is not rendered in a Hospital or by a psychiatrist, psychologist, licensed clinical social worker or person with a master's degree in social work.
- For services rendered by licensed professional counselors, marital and family therapists or counselors or licensed drug and alcohol counselors.
- For services rendered by midwives.
- 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. You must provide to us all documents needed to enforce our rights under this provision.

PREEXISTING CONDITION EXCLUSION

Your Benefits under this Certificate are subject to a Preexisting Condition Exclusion period. However, the Preexisting Condition Exclusion will only apply to you and/or a Dependent if the following conditions are met:

- **Six–month Look–back Rule**

  — The Preexisting Condition Exclusion must relate to a condition (whether physical or mental, and regardless of the cause of the condition) for which medical advice, diagnosis, care, or treatment was recommended or received within the six–month period ending on the Subscriber's Enrollment Date.

  — In order to be taken into account, the medical advice, diagnosis, care, or treatment must have been recommended or received from an individual licensed or similarly authorized to provide such services under state law and operating within the scope of practice authorized by state law.

  — The six–month look–back period is based on the six–month "anniversary date" of the Enrollment Date.

- **Length of Preexisting Condition Exclusion Period**

  The exclusion period cannot extend for more than 12 months (18 months for Late Enrollees*) after the Enrollment Date. The 12–month or 18–month "look forward" period is also based on the anniversary date of the Enrollment Date.

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

  In general, the Preexisting Condition Exclusion period must be reduced by the individual's days of "Creditable Coverage" as of the Enrollment Date. Creditable Coverage includes coverage from a wide range of specified sources, including Group Health Plans, health insurance coverage, Medicare, and Medicaid. However, days of Creditable Coverage that occur before a Significant Break In Coverage (63 or more consecutive days) will not be counted in reducing the Preexisting Condition Exclusion period.

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

- **Elimination of Preexisting Condition Exclusion for Pregnancy and for Certain Children**

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

- **Notice to Subscribers**

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

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

* *See the* ***Definitions*** *section for an explanation of this term.*

General Provisions

This section tells:

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

Benefits to Which Your 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 Precertification 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 90 days after the end of the Benefit Period for which claim is made.

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

Limitation of Actions

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

Payment of Benefits

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

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

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

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

Benefits for Services Outside the State of Oklahoma

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

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

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

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

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

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

Determination of Benefits and Utilization Review

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

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

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

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

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

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

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

Subscriber/Provider Relationship

The choice of a Provider is solely yours.

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

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

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

Agency Relationships

The Group is your agent, not our agent.

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

Coordination of Benefits

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

- **Definitions**

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

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

  — Group, blanket or franchise insurance coverage;

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

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

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

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

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

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

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

- **Effect On Benefits**

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

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

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

- **Order Of Benefit Determination**

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

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

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

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

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

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

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

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

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

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

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

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

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

- **Facility Of Payment**

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

- **Right Of Recovery**

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

PLAN'S RIGHT OF RECOUPMENT

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

To the extent the Plan provides or pays Benefits for Covered Services for any injury, illness or condition which occurs through the omission or commission of any act by another person, each Subscriber agrees that the Plan shall have a first lien on any settlement proceeds, and the Subscriber shall reimburse and pay the Plan, on a first–priority basis, from any money recovered by suit, settlement, judgment or otherwise from another party or his or her insurer or from any carrier providing uninsured/underinsured motorist coverage. Each Subscriber shall reimburse the Plan on a first–priority basis regardless of whether a lawsuit is actually filed or not and, if settled, regardless of how the settlement is structured or which items of damages are included in the settlement, and regardless of whether or not he or she is made whole or is fully compensated for any injuries.

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

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

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.

Plan's Separate Financial Arrangements with Pharmacy Benefit Managers

The Plan owns a significant portion of the equity of Prime Therapeutics LLC and informs you that the Plan has entered into one or more agreements with Prime Therapeutics LLC or other entities (collectively referred to as "Pharmacy Benefit Managers") to provide, on the Plan's behalf, claim payments and certain administrative services for your Prescription Drug Benefits. Pharmacy Benefit Managers have agreements with pharmaceutical manufacturers to receive rebates for using their products. The Pharmacy Benefit Manager may share a portion of those rebates with the Plan. Neither the Employer nor you are entitled to receive any portion of such rebates as they are figured into the pricing of the product.

Subscriber Rights

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

You have the right to:

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

Claims Filing Procedures

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

Participating Provider Networks

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

REMEMBER . . .

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

Prescription Drug Claims

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

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

Hospital Claims

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

Ambulatory Surgical Facility Claims

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

Physician and Other Provider Claims

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

Member–Filed Claims

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

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

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

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

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

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

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

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

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

Remember, we must receive your claims for Covered Services within 90 days after the end of the Benefit Period for which claim is made.

Benefit Determinations for Properly Filed Claims

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

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

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

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

DIRECT CLAIMS LINE

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

Complaint/Appeal Procedure

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

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

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

APPEAL PROCESS (LEVEL I)

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

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

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

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

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

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

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

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

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

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

— The Plan will respond to you no later than 72 hours after the appeal is received.

— The Plan's response to a Precertification Request involving Urgent Care, including an adverse determination, if applicable, may be issued orally. A written notice will also be provided within three days following the oral notification.

VOLUNTARY RE–REVIEW PROCESS (LEVEL II)

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

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

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

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

A Precertification Request Involving Urgent Care may be re–reviewed by calling the Precertification number shown on the Identification Card.

EXTERNAL REVIEW (LEVEL III)

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

You are not obligated by the Group Health Plan to pursue the Plan's voluntary re–review process or an external review in any specific order. You are not required to exhaust the voluntary re–review process before bringing a civil action. If the review process does not provide a satisfactory resolution to the claim for Benefits, legal remedies are available, including pursuing the claim in court.

Your ERISA Rights

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

ERISA Rights

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

Assistance with Your Questions

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

Definitions

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

Actively at Work

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

Allowable Charge

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

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

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

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

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

Ambulatory Surgical Facility

A Provider with an organized staff of Physicians which:

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

Annual Transfer Period

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

Benefit Period

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

Benefits

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

BlueCard PPO Provider

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

BlueChoice PPO Provider

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

Calendar Year

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

Certificate of Coverage

A document providing information which is intended to enable an individual to establish his/her prior Creditable Coverage for the purposes of reducing any Preexisting Condition Exclusion imposed on the individual by any subsequent Group Health Plan coverage.

COBRA Continuation Coverage

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

Coinsurance

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

Community Home Health Care Agency

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

Contract

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

Contract Date

The date when coverage for your Group starts.

Contract Date Anniversary

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

Covered Service

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

Creditable Coverage

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

Custodial Care

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

Deductible

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

Dependent

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

Diagnostic Service

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

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

Durable Medical Equipment

Equipment which meets the following criteria:

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

Effective Date

The date when your coverage begins.

Eligible Person

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

Emergency Care

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

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

Employee

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

Employer

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

Enroll

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

Enrollment Date

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

Experimental/Investigational

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

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

Family Coverage

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

Full-Time Student

A person who is regularly attending an accredited secondary school, college or university as:

- An undergraduate student enrolled in 12 or more semester hours, or the academic equivalent; or
- A graduate student enrolled in nine or more semester hours, or the academic equivalent; or
- A graduate assistant student enrolled in six or more semester hours, or the academic equivalent.

Group

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

Group Health Plan

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

Health Maintenance Organization (HMO)

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

Health Savings Account (HSA)

A trust created or organized in the United States as a Health Savings Account exclusively for the purpose of paying the qualified medical expenses of the account beneficiary.

Hospice

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

Hospital

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

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

Identification Card

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

Incurred

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

Individual Conversion

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

Initial Enrollment Period

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

Inpatient

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

Late Enrollee

An Eligible Person or Eligible Dependent who Enrolls under the Contract at a time other than during:

- the Initial Enrollment Period; or
- a Special Enrollment Period for the individual.

However, an Eligible Person or Eligible Dependent is not considered a Late Enrollee if:

- the individual transfers from the Employer's alternate Plan Group Contract or BlueLincs HMO (if applicable) during the Annual Transfer Period; or
- a court has ordered coverage be provided for a spouse or minor or Dependent child under the Eligible Person's coverage and the request for enrollment is made within 31 days after issuance of the court order.

Licensed Practical or Vocational Nurse (LPN or LVN)

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

Low–Dose Mammography

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

Maternity Services

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

Medical Care

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

Medically Necessary (or Medical Necessity)

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

- Appropriate for symptoms and diagnosis to treat the condition, illness, disease or injury; and
- In line with standards of good medical practice; and
- Not primarily for your or your Provider's convenience; and
- The most appropriate supply or level of service which can be safely provided to you. When applied to the care of an Inpatient, this means that your condition or the services you need require acute care as a bed patient and that you cannot receive safe or adequate care as an Outpatient.

Medicare

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

Member

An Eligible Person who has enrolled for coverage.

Member and Children Coverage

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

Member Only Coverage (or Single Coverage)

Coverage under this Certificate for the Member only.

Member, Spouse and Children Coverage (or Family Coverage)

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

Member and Spouse Only Coverage

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

Mental Illness

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

Open Enrollment Period

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

Orthognathic Surgery

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

Out–of–Network Pharmacy

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

Out–of–Network Provider

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

Out–of–Pocket Limit

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

- **Member–Only (Single) Coverage** — When you have satisfied the Out–of–Pocket Limit specified in the Schedule of Benefits, no additional Deductible or Coinsurance will be required for Covered Services you incur during the remainder of the Benefit Period.
- **Family Coverage** — When any *one or more* covered family members have paid the Out–of–Pocket Limit specified in the Schedule of Benefits, no additional Deductible or Coinsurance will be required for Covered Services Incurred by any Subscribers under that same Family Coverage during the remainder of the Benefit Period.

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

Outpatient

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

Participating Pharmacy

A Pharmacy that has entered into a Participating Pharmacy Agreement with the Plan.

Pharmacy

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

Physician

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

Placement for Adoption (or Placed for Adoption)

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

PLAN

Blue Cross and Blue Shield of Oklahoma.

PRECERTIFICATION

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

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

PREEXISTING CONDITION

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

PREEXISTING CONDITION EXCLUSION

A 12–month or 18–month period during which no Benefits will be provided for a condition for which medical advice, diagnosis, care or treatment was recommended or received within the six–month period before the Enrollment Date.

PRESCRIPTION DRUG

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

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.

QUALIFYING EVENT

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

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

REGISTERED NURSE (RN)

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

ROUTINE NURSERY CARE

Ordinary Hospital nursery care of the newborn Subscriber.

Significant Break In Coverage

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

Skilled Nursing Facility

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

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

Special Enrollment Period

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

Subscriber

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

Surgery

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

Therapy Service

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

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

Total Disability (or Totally Disabled)

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

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

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

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

WAITING PERIOD

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

BlueCross BlueShield of Oklahoma

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

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. Continuity of Care

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.

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

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

AMENDMENTS TO THE GROUP HEALTH PLAN

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

A. AMENDMENT RESPECTING COVERED INSULIN DRUG COST SHARE

1. The ***Schedule of Benefits for Outpatient Prescription Drugs and Related Services*** and the ***Outpatient Prescription Drugs and Related Services*** sections are hereby amended to add the following note:

   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.

2. The *"If you need drugs to treat your illness or condition" provision* of the ***Summary of Benefits and Coverage (SBC)*** section is hereby amended with the addition of the following:

   Your cost for a covered insulin drug will not exceed $30 per 30-day supply or $90 per 90-day supply.

B. AMENDMENT RESPECTING VIRTUAL VISITS

1. The *"Virtual Visits"* benefit of the ***Schedule of Benefits for Comprehensive Health Care Services*** is hereby amended with the addition of the following footnote, where applicable:

   Cost shares for Covered Services provided through Virtual Visits will be the same as if provided in-person, except where otherwise noted.

2. The bullet for "Benefits for Virtual Visits shall include" in The ***Comprehensive Health Care Services*** section is hereby the deleted.

3. The ***Comprehensive Health Care Services*** section is hereby amended by the addition of the new *"Virtual Visits"* provision below:

   VIRTUAL VISITS

   This plan provides Benefits for Medically Necessary Virtual Visits. Virtual Visits provide access to Providers in situations that may be appropriately handled using technology without a traditional in-person visit. Cost-sharing amounts for Covered Services provided through a Virtual Visit are usually the same as, and will not exceed, the cost share that would apply if those Covered Services were provided through a traditional in-person visit.

   Note: To be covered under the Virtual Visits benefit, a Covered Service must be appropriately provided through telemedicine. Virtual Visit benefits may be limited consistent with the coding and clinical standards recognized by the American Medical Association or the Centers for Medicare and Medicaid Services.

4. The *"Virtual Visits"* definition in the ***Definitions*** section is hereby deleted and replaced with the following:

   VIRTUAL VISITS

   Covered Services appropriately delivered by a licensed Provider using technology-enabled health and care management and delivery systems that extend capacity and access as allowed by applicable law. Also known as telehealth or telemedicine.

C. AMENDMENT RESPECTING COST SHARE REQUIREMENTS FOR PRESCRIPTION DRUGS

1. The ***Schedule of Benefits for Outpatient Prescription Drugs and Related Services*** is hereby amended with the addition of the following language:

   Any amounts paid by you, or on your behalf, for a Covered Drug will be used to calculate your cost-sharing requirements.

2. Any language indicating amounts paid by you, or on your behalf, for Covered Drugs will not be included when calculating your cost-sharing requirements, including any Copayment, Coinsurance, Deductible or Out-of-Pocket Limit, is hereby deleted in its entirety.

D. AMENDMENT RESPECTING BENEFIT DETERMINATIONS FOR PROPERLY FILED CLAIMS

1. The *"Benefit Determinations for Properly Filed Claims"* provision of the ***Claims Filing Procedures*** section is hereby deleted in its entirety and replaced with the following:

   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 in accordance with applicable state and federal law.

   Upon receipt of your claim, if the Plan determines that additional information is necessary in order for your claim to be a Properly Filed Claim, we will provide written notice to you and/or your Provider, in accordance with state and federal law, requesting the specific information needed.

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

2. The footnote for the "Pre-Service Claims" table and the "Post-Service Claims" table in the ***Complaint/Appeal Procedure*** section are hereby deleted.

This amendment is effective on the Group's first Contract Date Anniversary (renewal date) following November 1, 2021.

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

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

AMENDMENTS TO THE GROUP HEALTH PLAN

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

A. AMENDMENT RESPECTING PREAUTHORIZATION

1. Wherever the term "Preauthorization" appears in the Certificate is hereby deleted and replaced with "Prior Authorization".
2. The ***Important Information*** section is hereby amended as follows:

   - The "Medical Necessity Limitation" provision is hereby deleted.
   - The following provision entitled "Utilization Management" is hereby added:

     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"*.

   - The following provision entitled "Preauthorization" is hereby deleted and replaced with the following:

     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, "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 be approved through 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:

  - Hospice Services;
  - Home Health Care Services;
  - Dialysis Treatment (Out-of-Network services only);
  - Home Hemodialysis;
  - Private Duty Nursing Services;
  - Human Organ and Tissue Transplant services;
  - Molecular genetic testing;
  - Radiation Therapy;
  - Home Infusion Therapy;

- Outpatient Infusion Drugs;
- Outpatient Provider administered drug therapies, Cellular Immunotherapy, and Gene Therapy;
- 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.

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 the Plan 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.

If you fail to request Prior Authorization, your Benefits under this Certificate may be reduced, as described below under "Failure to Obtain Prior Authorization".

- **Failure to Obtain Prior Authorization**

  If the Subscriber does not call for Prior Authorization for **Inpatient services, Home Health Care Services or Hospice Services, listed above,** these services will be subject to a $500 reduction in Benefits if, upon receipt of a claim, it is determined by the Plan that services were Medically Necessary. If it is determined that the services were not Medically Necessary or were Experimental, Investigational and/or Unproven, it may be the Subscriber's responsibility to pay the full cost of the services received.

  If the Subscriber fails to obtain Prior Authorization for the other Outpatient services listed above:

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

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

- The following provision entitled "Length of Stay/Service Review" is hereby added:

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 Prior Authorization Process for Inpatient Services or the Prior Authorization Requests Involving Emergency Care review, the Plan 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).

- The following provision entitled "Predetermination Review" is hereby added.

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.

- The following provision entitled "Post-Service Medical Necessity Review" is hereby added.

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.

- The "Concurrent Review" provision is hereby deleted.

3. The ***Definitions*** section is updated as follows:

- The following definition for "Post-Service Medical Necessity Review" has been added:

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.

- The "Preauthorization/Precertification" definition has been deleted.

- The "Predetermination" definition below has been added:

PREDETERMINATION

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.

- The following definition for "Prior Authorization" has been added:

PRIOR AUTHORIZATION

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

B. AMENDMENT RESPECTING YOUR PRESCRIPTION DRUG PROGRAM

The ***Important Information*** section is amended so that the provision for "*Your Prescription Drug Program"* is hereby deleted and replaced with the following:

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 Participating Pharmacy are processed at the highest level of Benefits.**

In order to receive the highest level of Benefits for your prescription charges, *your prescriptions must be filled at a Participating Pharmacy*. **Your coverage under this program is subject to a reduction in Benefits if your prescriptions are filled at a Pharmacy which is not a member of the Participating Pharmacy network.**

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. And, because your pharmacist will not be able to submit your claim electronically, he/she will not be able to apply the discount for your prescriptions.

C. AMENDMENT RESPECTING MENTAL ILLNESS

1. Wherever the term "Mental Illness" appears in the Certificate is hereby deleted and replaced with "Mental Health and Substance Use Disorder".
2. The ***Definitions*** section is amended so that the title of the definition "Mental Illness" is hereby deleted and replaced by the title "Mental Health and Substance Use Disorder".

D. AMENDMENT RESPECTING CLINICAL LANGUAGE

The ***Comprehensive Health Care Services*** section is hereby amended to include the following:

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/Unproven, cosmetic, or a convenience item. The clinical procedure and coding policies provide information about what services are reimbursable under the Plan. The most up-to-date medical and clinical procedure and coding policies are available at www.bcbsok.com or by contacting a Customer Service Representative at the number shown on your Identification Card.

E. AMENDMENT RESPECTING THERAPEUTIC EQUIVALENT RESTRICTIONS

The "*Therapeutic Equivalent Restrictions"* provision of the ***Outpatient Prescription Drugs and Related Services*** section is hereby deleted and replaced with the following:

Some drugs have therapeutic equivalents/therapeutic alternatives. In some cases, the Plan may limit benefits to only certain therapeutic equivalents/therapeutic alternatives. If you do not choose the therapeutic equivalents/therapeutic alternatives that are covered under your benefit, the drug purchased will not be covered under any Benefit level.

F. AMENDMENT RESPECTING EXCLUSIONS

The ***Exclusions*** section set forth is amended as follows:

1. The exclusion "for conditions related to hyperkinetic syndromes, learning disabilities, mental retardation, or for Inpatient confinement for environmental change" is hereby removed.
2. The exclusion "for unspecified developmental disorders" is hereby deleted and replaced by the following:

   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"*.
3. The following exclusion is hereby added:

   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"*.

This amendment is effective on the Group's first Contract Date Anniversary (renewal date) following April 1, 2022.

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

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

AMENDMENTS TO THE GROUP HEALTH PLAN

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

A. AMENDMENT RESPECTING EMERGENCY CARE SERVICES

The ***Comprehensive Health Care Services*** section is amended so that the provision for "Emergency Care Services" is hereby amended with the addition of the following:

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 Illness will be paid the same as Emergency Care services.

B. AMENDMENT RESPECTING DIABETES EQUIPMENT, SUPPLIES AND SELF-MANAGEMENT SERVICES

The ***Comprehensive Health Care Services*** section is amended so that the provision for "Diabetes Equipment, Supplies and Self-Management Services" is amended by the following:

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 supplies;
  - 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 when the patient has successfully completed the 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").

C. AMENDMENT RESPECTING PROSTHETIC APPLIANCES

The ***Comprehensive Health Care Services*** section is amended so that the "Prosthetic Appliances" sentence regarding Medical Necessity is hereby updated with the following:

Benefits for replacement appliances will be provided only when determined to be Medically Necessary due to changes in the size of the limb being augmented.

D. AMENDMENT RESPECTING EXCLUSIONS

The ***Exclusions*** section set forth in the Certificate is amended as follows:

- The exclusion for "Continuous Passive Motion (CPM) devices" is hereby deleted and replaced by the following:

  - For Continuous Passive Motion (CPM) devices used in treatment of the shoulder or other joints, except for up to 21 days postoperatively for certain knee procedures determined to be Medically Necessary per our medical policy.

– The following exclusion is hereby added:

  - Refractions, including lens prescriptions, corrective eyeglasses and frames, contact lenses (including the fitting of the lenses), or toric or accommodating intraocular lens implants except as may be specifically provided for in the ***Schedule of Benefits for Covered Health Care Services***. Refractive surgery is excluded.

E. AMENDMENT RESPECTING THE PLAN'S SEPARATE FINANCIAL ARRANGEMENTS WITH PRESCRIPTION DRUG PROVIDERS

The ***General Provisions*** section of the Certificate is amended so that the maximum that Prime will receive from any pharmaceutical manufacturer for certain administrative fees will be 5.5% 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.

F. AMENDMENT RESPECTING THE OKLAHOMA INSURANCE DEPARTMENT'S ADDRESS

The Oklahoma Insurance Department's address, wherever used in the Certificate and Notices, is hereby updated to the address below:

Oklahoma Insurance Department
400 NE 50th Street
Oklahoma City, OK 73105

This amendment is effective on the Group's first Contract Date Anniversary (renewal date) following January 1, 2021.

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

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AMENDMENTS RESPECTING OUTPATIENT PRESCRIPTION DRUGS

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

The ***Outpatient Prescription Drug Benefits section*** or ***Outpatient Prescription Drugs and Related Services*** section of your Certificate is amended as set forth below:

A. COVERED SERVICES

The benefits of this section are amended as set forth below:

- The following provision clarifying Prescription Drugs has been added:
  - Prescription Drugs are drugs that are required by federal and state law to be dispensed only by prescription.
- The benefits regarding Oral Chemotherapy are hereby deleted and replaced with the following:
  - Oral chemotherapy when prescribed by a licensed physician. Your Deductible, Copayment and/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.
- The benefits regarding Self-Injectables and Other Self-Administered Prescription Drugs are hereby deleted and replaced with the following:
  - 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 in order to receive the highest level of benefits.
- The benefits regarding Specialty Pharmacy Drugs is hereby deleted and replaced with the following:
  - Specialty Pharmacy Drugs, limited to a 30-day supply per Prescription Order, will be subject to the Deductible, Copayment and/or Coinsurance provisions.

B. PRESCRIPTION DRUG SUPPLY/DISPENSING LIMITS

The provisions of this section are hereby amended as set forth below:

- The "Benefit Supply Limits per Prescription" provision is amended with the updating of the following bullet:

- During each one-month period, up to a 30-day supply or 120 units (e.g. pills), whichever is less, for Prescription Drugs. If more than 120 units are needed to reach a 30-day supply, another Coinsurance amount will apply to each additional 120 units (or portion thereof) purchased.

- The "Controlled Substances Limitations" provision is hereby deleted and replaced with the following:

  - **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 treatment guidelines, any coverage for additional drugs may be subject to a review for Medical Necessity, appropriateness and other coverage which may include but not limited to 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. Additional Copayments and/or Coinsurance may apply. For the purposes of this provision, controlled substance medications are medications classified and restricted by state or federal laws.

C. THERAPEUTIC EQUIVALENT RESTRICTIONS

The provision regarding "Therapeutic Equivalent Restrictions" is hereby deleted and replaced with the following:

Some therapeutic equivalent drugs are manufactured under multiple names. In some cases, Benefits may be limited to only one of the therapeutic equivalents available. If you do not choose the therapeutic equivalents that are covered under this Benefit section, the drug purchased will not be covered under any Benefit level.

D. THE PLAN'S SEPARATE FINANCIAL ARRANGEMENTS WITH PRESCRIPTION DRUG PROVIDERS

The ***General Provisions*** section of the Certificate is amended so that the maximum that Prime will receive from any pharmaceutical manufacturer for certain administrative fees will be 5.5% 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.

This amendment is effective on the Group's first Contract Date Anniversary (renewal date) following January 1, 2021.

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.

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AMENDMENT RESPECTING PSYCHIATRIC CARE SERVICES

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

A. The ***Schedule of Benefits*** and ***Comprehensive Health Care Services*** section are amended as follows:

- Benefits for the treatment of Psychiatric Care Services, including treatment of drug abuse and alcoholism, shall be equal to the Benefits provided under this Certificate for the treatment of all other physical diseases and disorders, subject to the same provisions regarding:
  - Deductible, Copayment (if applicable) and/or Coinsurance provisions; and
  - Preauthorization and utilization review mechanisms.
- The Benefits set forth in your Certificate of Benefits for the treatment of Psychiatric Care Services are hereby amended as set forth below:
  - The "Office Visit Copayment" (if applicable) shall be applied to Psychiatric Care Services on the same basis as such Copayment provisions are applied to office visits related to treatment of any other medical condition.
  - Covered Psychiatric Care Services shall be paid at the same Benefit percentage rate applicable to other covered Hospital Services and Surgical/Medical Services.
  - Covered Psychiatric Care Services shall count toward the Out-of-Pocket Limit applicable to all other Covered Services.
  - The Inpatient stay limits and Outpatient visit limits specified in your Certificate for treatment of Psychiatric Care Services shall no longer be applicable.

B. The terms "substance abuse" or "substance abuse disorders", wherever used in the Certificate is hereby deleted.

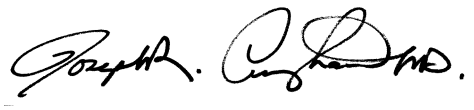
C. The ***Definitions*** section is amended so that the definition of "Mental Illness" is hereby deleted and replaced by the following:

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.

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.

The above changes to your Group Health Plan are effective on the first of the following dates occurring on November 1, 2020.



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AMENDMENTS TO THE GROUP HEALTH PLAN

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

A. **AMENDMENT RESPECTING PREAUTHORIZATION PROCESS FOR CERTAIN OUTPATIENT SERVICES**

The provisions outlining "Preauthorization Process for Certain Outpatient Services" under *"Preauthorization"* are hereby deleted and replaced by the following:

- **Preauthorization Process for Certain Outpatient Services**

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

  - Hospice Services;
  - Home Health Care Services;
  - Home Hemodialysis;
  - Private Duty Nursing Services;
  - Human Organ and Tissue Transplant services (including transplant evaluations);
  - Molecular genetic testing;
  - Radiation Therapy;
  - Home Infusion Therapy;
  - 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):**
    - Cardiac Advanced Imaging Services: MRI, Magnetic Resonance Angiogram (MRA), PET, PET-CT, CT, Computed Tomography Angiography (CTA), Nuclear Medicine;
    - 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;
  - Functional Neuromuscular Electrical Stimulation (FNMES);
  - 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 (including Cardiology).
- **Surgical Procedures:**
  - Orthognathic Surgery; Face reconstruction;
  - Mastopexy; Breast lift;
  - Reduction Mammoplasty; Breast Reduction.
- **Wound Care:**
  - Hyperbaric Oxygen (HBO2) Therapy).

For specific details about the Preauthorization 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 Preauthorization is subject to review and change by Blue Cross and Blue Shield of Oklahoma. The Plan reserves the right to no longer require Preauthorization during the Benefit Period for any or all the above listed Outpatient services.

If you fail to request Preauthorization, your Benefits under this Certificate may be reduced, as described below under "Failure to Preauthorize".

B. **AMENDMENT RESPECTING ORAL CHEMOTHERAPY**

Benefits for oral chemotherapy as outlined under "Covered Services" in the ***Outpatient Prescription Drugs and Related Services*** section of the Certificate is replaced and restated as follows:

- Oral Chemotherapy when prescribed by a licensed Physician. Your Deductible, Copayment and/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 subject to applicable Deductible, Copayment and/or Coinsurance; however, Benefits 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 may be purchased from a Participating Specialty Pharmacy.

C. **AMENDMENT RESPECTING AMENDMENT RESPECTING EXCLUSIONS**

The ***Exclusions*** section and/or 'Exclusions and Limitations" set forth in the Certificate are amended as follows:

- The exclusion for "telephone consultations, email or other electronic consultations" is hereby deleted and replaced by the following:
  - For missed appointments or completion of a claim form.
- The exclusion for "self-administered drugs dispensed by a Physician" is hereby deleted and replaced by the following:
  - For any self-injectable and other self-administered drugs purchased from a Physician and administered in his/her office.

D. **AMENDMENT RESPECTING OUT-OF-AREA-SERVICES**

The provisions outlining "BlueCard® Program" in the ***General Provisions*** section are amended by the addition of the following:

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

E. **AMENDMENT RESPECTING BLUE CROSS BLUE SHIELD GLOBAL CORE SERVICE CENTER**

Wherever the name "Blue Shield Global Core Service Center" appears in the Certificate is hereby deleted and replaced with "service center".

This amendment is effective on the Group's first Contract Date Anniversary (renewal date) following October 15, 2019.

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

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AMENDMENTS TO THE GROUP HEALTH PLAN

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

A. **AMENDMENT RESPECTING PREAUTHORIZATION PROCESS FOR CERTAIN OUTPATIENT SERVICES**

The provisions outlining "Preauthorization Process for Certain Outpatient Services" under *"Preauthorization"* are hereby deleted and replaced by the following:

- **Preauthorization Process for Certain Outpatient Services**

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

  - Hospice Services;
  - Home Health Care Services;
  - Private Duty Nursing Services;
  - Molecular genetic testing;
  - 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):**
    - Cardiac Advanced Imaging;
    - Stress Testing (Myocardial Perfusion Imaging – Single-Photon Emission Computed Tomography (SPECT) and Positron emission tomography (PET));
    - Cardiac computed tomography (CT) and Magnetic Resonance Imaging (MRI);
    - Echocardiography (Stress, Transthoracic and Transesophageal);
    - Diagnostic Heart Catheterization;
    - Implantable Device Services: Pacemakers, Implantable Cardioverter-Defibrillators;

- MRI, Magnetic Resonance Angiogram (MRA), PET, PET-CT, CT, Computed Tomography Angiography (CTA), Nuclear Medicine;
- 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):**
  - Arthroscopic, Open and Joint Replacement Surgeries for the Shoulder, Hip and Knee;
  - Artificial Intervertebral Disc;
  - Autologous Chondrocyte Implantation (ACI) for Focal Articular Cartilage Lesions;
  - Femoroacetabular Impingement (FAI) Syndrome;
  - Functional Neuromuscular Electrical Stimulation (FNMES);
  - Lumbar Spinal Fusion;
  - Meniscal Allografts and Other Meniscal Implants;
  - Orthopedic Applications of Stem-Cell Therapy;
  - Spinal Decompression and Fusion Surgeries;
  - Total Disc Replacement surgery;
  - Pneumatic Compression Devices – Durable Medical Equipment (DME).
- **Pain Management**
  - Occipital Nerve Stimulation;
  - Epidural Steroid Spinal Injections;
  - Surgical Deactivation of Headache Trigger Sites;
  - Facet Joint Spinal Injections;
  - Radiofrequency Spinal Facet Joint Ablation/Denervation;
  - Spinal Cord Stimulators;
  - Regional Sympathetic Blocks;
  - Sacroiliac Joint Injections;
  - Implantable Intrathecal Drug Delivery Systems;
  - Percutaneous and Implanted Nerve Stimulation and Neuromodulation;
  - Spinal Cord Stimulation.

- **Radiology**
  - Diagnostic Ultrasound: Head and Neck, Pediatric, Breast, Abdomen and Retroperitoneum, Extremity, Arterial and Venous:
  - Radiation Therapy.
- **Sleep Medicine:**
  - Attended sleep studies and home sleep testing;
  - Positive Airway Pressure (PAP) therapy devices and supplies (Sleep Continuous Positive Airway Pressure (CPAP) and BiLevel Positive Airway Pressure (BiPAP) machines);
  - PAP therapy compliance monitoring and intervention for non-compliance;
  - Diagnostic studies for obstructive sleep apnea.
- **Surgical Procedures:**
  - Orthognathic Surgery; Face reconstruction;
  - Mastopexy; Breast lift;
  - Reduction Mammoplasty; Breast Reduction.
- **Wound Care:**
  - Hyperbaric Oxygen (HBO2) Therapy).
- **Therapies:**
  - Physical;
  - Occupational;
  - Speech and Language.

For specific details about the Preauthorization 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 Preauthorization is subject to review and change by Blue Cross and Blue Shield of Oklahoma. The Plan reserves the right to no longer require Preauthorization during the Benefit Period for any or all the above listed Outpatient services.

If you fail to request Preauthorization, your Benefits under this Certificate may be reduced, as described below under "Failure to Preauthorize".

B. **AMENDMENT RESPECTING PREVENTIVE CARE**

The 'Preventive Care Services' provisions outlined in the ***Comprehensive Health Care Services*** section are amended by the addition of the following:

Preventive Care Services will be implemented in the quantities and within the time periods allowed under applicable law.

C. **AMENDMENT RESPECTING EMERGENCY CARE SERVICES**

The ***Comprehensive Health Care Services*** and ***Definitions*** sections are amended so that the provision/definition for "Emergency Care Services" is hereby deleted and replaced by the following:

EMERGENCY CARE SERVICES

Services provided in a Hospital emergency department (emergency room) or 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.

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"*).

D. **AMENDMENT RESPECTING VIRTUAL VISITS**

The ***Schedule of Benefits*** and ***Comprehensive Health Care Services*** section are amended by the addition of Virtual Visits as set forth below:

- Benefits for Virtual Visits shall include 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 Illness conditions in situations that may be handled without a traditional office visit, urgent care visit or Emergency Care visit.
- The "Office Visit Copayment" (if applicable) shall be applied to Virtual Visits on the same basis as such Copayment provisions are applied to office visits related to treatment of non-emergency medical and Mental Illness conditions.

E. **AMENDMENT RESPECTING EXCLUSIONS**

The ***Exclusions*** section is amended so that the exclusions for "Inpatient treatment of any non-covered dental procedure" is hereby deleted and replaced by the following:

- 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 practitioner treating the child, is not of sufficient emotional development to undergo a Medically Necessary dental procedure without the use of anesthesia.

F. **AMENDMENT RESPECTING NON-PARTICIPATING PROVIDERS OUTSIDE THE BLUE CROSS AND BLUE SHIELD OF OKLAHOMA SERVICE AREA**

The provisions outlining 'Non-Participating Providers Outside the Blue Cross and Blue Shield of Oklahoma Service Area' of the ***General Provisions*** section are hereby deleted and replaced by the following:

- **Non-Participating Providers Outside the Blue Cross and Blue Shield of Oklahoma 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 pay for such services will be calculated using the methodology described in the Certificate for Non-Contracting 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.

G. AMENDMENT RESPECTING BLUECARD WORLDWIDE NAME CHANGE

Wherever the name "BlueCard Worldwide" appears in the Certificate is hereby deleted and replaced with "Blue Cross Blue Shield Global Core".

H. AMENDMENT RESPECTING THE PLAN'S RIGHT OF RECOUPMENT

The ***General Provisions*** section is amended so that the provisions outlining 'Plan's Right of Recoupment' are hereby deleted in their entirety and replaced by the following:

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 Covered Services 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 another 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 and 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 and Blue Shield of Oklahoma plan's or policy's Overpayment to the same Provider and remit the recovered amount to the other Blue Cross and Blue Shield of Oklahoma 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.

I. AMENDMENT RESPECTING DEFINITIONS

The ***Definitions*** section is amended as set forth below.

° The following definitions are hereby deleted and restated:

– **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.

– **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.

- The following definition is hereby added:

  VIRTUAL VISITS

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

This amendment is effective on the Group's first Contract Date Anniversary (renewal date) following February 1, 2018.

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

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

AMENDMENT RESPECTING OUTPATIENT PRESCRIPTION DRUGS

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

The ***Outpatient Prescription Drug Benefits*** section of your Certificate is amended as follows.

A. **PRESCRIPTION DRUG SUPPLY/DISPENSING LIMITS**

The provisions of this section are amended so that the Controlled Substance Limitation provision is hereby deleted and restated as follows:

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 treatment guidelines, Benefits may be subject to a review to determine Medical Necessity, appropriateness and other restrictions such as limiting coverage to services provided by a certain Provider and/or Participating 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.

B. The provision outlining Therapeutic Equivalent Restrictions is hereby deleted and restated as follows:

THERAPEUTIC EQUIVALENT RESTRICTIONS

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

C. The Exclusions and Limitations outlined in this section are amended as follows:

- The following exclusions are hereby added:
  - Non-FDA approved drugs.
  - 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.
  - Any self-administered drugs dispensed by a Physician.
- The following exclusions are hereby deleted and restated as follows:
  - Devices or Durable Medical Equipment of any type (even though such devices may require a Prescription Order), such as, but not limited to, contraceptive devices, therapeutic devices, artificial appliances or similar devices (**except** lancets, test strips, and disposable hypodermic needles and syringes for self-administered injections). However, coverage for prescription contraceptive devices is provided under the ***Comprehensive Health Care Services*** section of your Certificate.
  - Diagnostic agents, except diabetic testing supplies or test strips.

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.

The above changes to your Group Health Plan are effective on the first of the following dates occurring on or after February 1, 2018:

1. **the Group Contract Date;**
2. **the Group's first Contract Date Anniversary (renewal date); or**
3. **the first Plan Year of the Group Health Plan.**

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AMENDMENTS TO THE GROUP HEALTH PLAN

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

A. **AMENDMENT RESPECTING BREAST-FEEDING SUPPORT, SERVICES AND SUPPLIES**

Benefits for electric breast pumps are limited to a maximum of one per Benefit Period.

B. **AMENDMENT RESPECTING EMERGENCY CARE SERVICES**

The ***Comprehensive Health Care Services*** and ***Definitions*** sections are amended so that the provision/definition of "Emergency Care Services" is hereby deleted and replaced by the following:

EMERGENCY CARE SERVICES

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

- serious jeopardy to the Subscriber's health (or, with respect to a pregnant woman, the health of the woman or her unborn child);
- serious impairment to bodily function;
- 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.

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

C. **AMENDMENT RESPECTING AMBULANCE SERVICES**

The ***Comprehensive Health Care Services*** section is amended so that provisions outlining "Ambulance Services" are hereby deleted and replaced by the following:

- 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 only covered 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.

D. **AMENDMENT RESPECTING EXCLUSIONS**

The ***Exclusions*** section set forth in the Certificate is amended as follows:

- The exclusion for "payments provided under Medicare or governmental units" is hereby deleted and replaced by the following:
  - 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).
- The exclusion for "sexual problems" is hereby deleted and replaced by the following:
  - For treatment of sexual dysfunction not caused by organic disease.
- The following exclusion is hereby added:
  - For transportation services, except as described under "Ambulance Services" in the ***Comprehensive Health Care Services*** section of the Certificate.

E. **AMENDMENT RESPECTING GENERAL PROVISIONS**

The ***General Provisions*** section is amended as set forth below:

- The provisions under the heading "Out-of-Area Services" are amended by the addition of the following:

  In some cases, the Plan may, but is not required to, in its sole and absolute discretion, negotiate a payment with such non-participating health care Provider on an exception basis.

- The following provision is hereby added:

  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. 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.

This amendment is effective on the Group's first Contract Date Anniversary (renewal date) following September 1, 2017.

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

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AMENDMENT RESPECTING OUTPATIENT PRESCRIPTION DRUG BENEFITS

IT IS AGREED that the Group Contract, Individual Conversion Contract or Certificate of Benefits to which this amendment is issued for attachment is amended so that the provision outlining Prescription Drug refills is hereby deleted and replaced by the following:

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 the 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.

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 Contract or Certificate to which this amendment is attached will remain in full force and effect.

This amendment is effective November 1, 2017.

President of Blue Cross and Blue Shield of Oklahoma

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AMENDMENTS TO THE GROUP HEALTH PLAN

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

A. **AMENDMENT RESPECTING CONVERSION PRIVILEGES**

The "Conversion Privilege After Termination of Group Coverage" provisions of the Group Health Plan are hereby removed and shall no longer apply to any Subscriber.

B. **AMENDMENT RESPECTING TOBACCO USE COUNSELING**

The ***Comprehensive Health Care Services*** section is amended so that the 'Preventive Care Services' provision related to smoking cessation is hereby deleted and restated as follows:

Tobacco use counseling and interventions (including a screening for tobacco use, counseling, and FDA-approved tobacco cessation medications).

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

C. **AMENDMENT RESPECTING PSYCHIATRIC CARE SERVICES**

The Benefits for "Psychiatric Care Services" are hereby deleted and replaced by the following:

PSYCHIATRIC CARE SERVICES

All Inpatient services and certain Outpatient services are subject to the "*Preauthorization*" 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 Illness:

- 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 Illness by a Hospital, Psychiatric Hospital, Residential Treatment Center, Physician, or other Plan-approved Provider.

- Drug Addiction, Substance Abuse and Alcoholism

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

D. **AMENDMENT RESPECTING SERVICES RELATED TO CLINICAL TRIALS**

The ***Comprehensive Health Care Services*** section is amended so that the *"Services Related to Clinical Trials"* provisions are hereby deleted and replaced by the following:

SERVICES RELATED TO CLINICAL TRIALS

Subject to the ***Exclusions***, conditions and limitations of this Member Handbook (including the Copayment, Coinsurance and/or Deductible provisions set forth in the ***Schedule of Benefits for Covered Health Care Services***), Benefits will be provided for Routine Patient Costs when provided in connection with a phase I, phase II, phase III, or phase IV clinical trial, that 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 Member Handbook 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.

E. **AMENDMENT RESPECTING OUT-OF-AREA SERVICES**

The "BlueCard" provisions of your Certificate are hereby deleted and replaced by the following:

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 health care 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.

  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-Contracting Providers Outside the Blue Cross and Blue Shield of Oklahoma Service Area**

  - **Subscriber Liability Calculation**

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

    If you need Emergency Care, Blue Cross and Blue Shield of Oklahoma will cover you at the highest level that federal regulations allow. You will have to pay for any charges that exceed the Allowable Charge as well as for any Deductibles, Copayments, Coinsurance and amounts that exceed any Benefit maximums. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

  - **Exceptions**

    In certain situations, the Host Plan's pricing may be unavailable. In that event, we will calculate the pricing for your claim in accordance with the "Allowable Charge" provisions set forth in the ***Important Information*** and ***Definitions*** sections of your Certificate. In these situations, you may be liable for the

difference between the amount that the non-contracting health care Provider bills and the payment we make for the Covered Services.

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

  Federal or state laws or regulations may require a surcharge, tax or other fee. 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.

- **BlueCard Worldwide® Program**

  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 the BlueCard Worldwide® Program when accessing Covered Services. The BlueCard Worldwide Program is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the BlueCard Worldwide Program 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 BlueCard Worldwide 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.

  - **Inpatient Services**

    In most cases, if you contact the BlueCard Worldwide 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 BlueCard Worldwide 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.

    You must contact Blue Cross and Blue Shield of Oklahoma to obtain Preauthorization for non-emergency Inpatient services.

  - **Outpatient Services**

    Physicians, urgent care centers and other Outpatient Providers located outside the BlueCard 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 BlueCard Worldwide 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 BlueCard Worldwide International claim form and send the claim form with the Provider's itemized bill(s) to the BlueCard Worldwide 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 BlueCard Worldwide Service Center or online at www.bluecardworldwide.com. If you need assistance with your claim submission, you should call the BlueCard Worldwide 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 in order to obtain Provider discounts for Covered Services you receive outside the state of Oklahoma.

F. **AMENDMENT RESPECTING EXCLUSIONS**

The ***Exclusions*** section set forth in the Certificate is amended as follows:

- The exclusion for "transsexual Surgery" is hereby deleted and replaced by the following:

  - For gender reassignment Surgery or any treatment leading to or in connection with gender reassignment Surgery.

- The exclusion for "Orthognathic Surgery, osteotomy, or any other form of oral Surgery, dentistry or dental processes" is hereby deleted and replaced by the following:

  - 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.

- The exclusion for "obesity, including morbid obesity" is hereby deleted and replaced by the following:

  - 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.

G. AMENDMENT RESPECTING ADVERSE BENEFIT DETERMINATION

The ***Complaint/Appeal Procedure*** section is amended so that the definition of "Adverse Benefit Determination" is hereby deleted and replaced by the following:

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.

H. AMENDMENT RESPECTING EXTERNAL REVIEW RIGHTS

The ***Complaint/Appeal Procedure*** section is amended so that the provisions outlining "External Review Rights" are hereby deleted and restated as follows:

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

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.

The above changes to your Group Health Plan are effective on the first of the following dates occurring on or after January 1, 2016:

1. **the Group Contract Date;**
2. **the Group's first Contract Date Anniversary (renewal date); or**
3. **the first Plan Year of the Group Health Plan.**

President of Blue Cross and Blue Shield of Oklahoma

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AMENDMENTS TO THE GROUP HEALTH PLAN

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

A. AMENDMENT RESPECTING PREAUTHORIZATION

The *"Preauthorization"* provisions of the ***Important Information*** section are hereby deleted and replaced by the following:

PREAUTHORIZATION

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

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

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

- **Preauthorization Process for Inpatient Services**

  For an Inpatient facility stay, *you must request Preauthorization from the Plan* ***before*** *your scheduled admission.* The Plan will consult with your Physician, Hospital, or other facility to determine if Inpatient level of care is required for your illness or injury. The Plan may decide that the treatment you need could be provided just as effectively in a different setting (such as the Outpatient department of the Hospital, an Ambulatory Surgical Facility, or the Physician's office). If the Plan determines that your treatment does not require Inpatient care, you and your Provider will be notified of that decision.

  If you proceed with an Inpatient stay without the Plan's approval, or if you do not ask the Plan for Preauthorization, your Benefits under the Certificate will be reduced, as described below under *"Failure to Preauthorize"*, provided the Plan determines that Benefits are available upon receipt of a claim. This reduction applies *in addition* to any Benefit reduction associated with your use of an Out-of-Network Provider, if applicable.

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

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

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

- **Preauthorization Requests Involving Emergency Care**

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

- **Preauthorization Process for Certain Outpatient Services**

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

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

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

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

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

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

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

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

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

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

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

  - could seriously jeopardize the life or health of the Subscriber or the ability of the Subscriber to regain maximum function; or
  - in the opinion of a Physician with knowledge of the Subscriber's medical condition, would subject the Subscriber to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Preauthorization request.

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

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

- **Failure to Preauthorize**

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

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

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

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

B. AMENDMENT RESPECTING CONCURRENT REVIEW

The *"Concurrent Review"* provisions of the ***Important Information*** section are hereby deleted and replaced by the following:

CONCURRENT REVIEW

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

C. AMENDMENT RESPECTING SERVICES RECEIVED OUTSIDE THE STATE OF OKLAHOMA

The ***Important Information*** section is amended so that the *"Allowable Charge"* provisions related to the processing of Out-of-Network Provider claims for services received outside the state of Oklahoma are deleted and replaced by the following:

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

D. AMENDMENT RESPECTING DESIGNATING AN AUTHORIZED REPRESENTATIVE

The ***Important Information*** section is amended so that the paragraph entitled *"Designating an Authorized Representative"* is hereby deleted and replaced by the following:

DESIGNATING AN AUTHORIZED REPRESENTATIVE

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

E. AMENDMENT RESPECTING MEDICAL NECESSITY

The ***Definitions*** section is amended so that the definition of "Medically Necessary (or Medical Necessity)" is hereby deleted and replaced by the following definition:

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.

F. AMENDMENT RESPECTING DEPENDENT ELIGIBILITY

The term "Dependent child", wherever used in the Certificate is amended to include an eligible foster child.

G. AMENDMENT RESPECTING PREEXISTING CONDITION PROVISIONS

The Preexisting Condition provisions of the Group Health Plan are hereby removed and shall not be applied to any Subscriber, regardless of age.

H. AMENDMENT RESPECTING NON-DISCRIMINATION

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 the 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.

I. AMENDMENT RESPECTING ENROLLMENT WAITING PERIOD

The ***Eligibility, Enrollment, Changes and Termination*** section of your Certificate is amended by the addition of the following provision:

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.

J. AMENDMENT RESPECTING RESCISSION/TERMINATION OF COVERAGE

The ***Eligibility, Enrollment, Changes and Termination*** section is amended so that any reference to the term "material misrepresentation" is replaced by "intentional misrepresentation of material fact".

K. AMENDMENT RESPECTING CREDITABLE COVERAGE

The *"Certificates of Creditable Coverage"* provisions of the Group Health Plan are hereby removed and shall no longer apply to any Subscriber.

L. AMENDMENT RESPECTING SERVICES RELATED TO CLINICAL TRIALS

The ***Comprehensive Health Care Services*** section is amended so that the *"Services Related to Clinical Trials"* provisions are hereby deleted and replaced by the following:

SERVICES RELATED TO CLINICAL TRIALS

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

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

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

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

M. AMENDMENT RESPECTING SMOKING CESSATION

If your Outpatient Prescription Drug Benefits include an exclusion for smoking cessation products, that exclusion will no longer apply.

N. AMENDMENT RESPECTING BENEFIT MAXIMUMS

The Benefit Period ***dollar*** maximums shown in the ***Schedule of Benefits***, ***Comprehensive Health Care Services*** section or in any amendment or endorsement issued thereto are amended as set forth below:

1. Orthotic Devices are limited to a maximum of 15 per Benefit Period. The Benefit Period ***dollar*** maximum is hereby removed.
2. Wigs and Scalp Prostheses are limited to a maximum of one per Benefit Period. The Benefit Period ***dollar*** maximum is hereby removed.

O. **AMENDMENT RESPECTING OUTPATIENT PRESCRIPTION DRUG BENEFITS AND RELATED SERVICES**

The ***Outpatient Prescription Drug Benefits*** section or ***Outpatient Prescription Drugs and Related Services*** section of your Certificate are amended by the addition of the following provision:

Coverage of prescribed orally administered anticancer medications will be provided on a basis no less favorable than intravenously administered or injected cancer medications.

P. **AMENDMENT RESPECTING EXCLUSIONS**

The ***Exclusions*** section set forth in the Certificate is amended as follows:

- The exclusion for "elective abortion" is hereby deleted and replaced by the following exclusion:
  - For any services related to elective abortion, unless the life of the mother is endangered.
- The exclusion for "work-related illness or injury" is hereby deleted and replaced by the following exclusion:
  - 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.

Q. **AMENDMENT RESPECTING NOTICE AND PROPERLY FILED CLAIM**

The ***General Provisions*** and ***Claims Filing*** sections are amended so that the reference to 90 days for submission of a Properly Filed Claim are removed and replaced by the following:

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

R. **AMENDMENT RESPECTING COORDINATION OF BENEFITS**

The ***General Provisions*** section is amended so that the provisions outlining *"Coordination of Benefits"* are deleted in their entirety and replaced by the following provisions:

COORDINATION OF BENEFITS

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

- **Definitions**

  In addition to the Definitions of the 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 the 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.

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.

The above changes to your Group Health Plan are effective on the first of the following dates occurring on or after January 1, 2015:

1. **the Group's first Contract Date Anniversary (renewal date); or**
2. **the first Plan Year of the Group Health Plan.**

President of Blue Cross and Blue Shield of Oklahoma

BlueCross BlueShield of Oklahoma

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AMENDMENTS TO THE GROUP HEALTH PLAN

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

A. **AMENDMENT RESPECTIVE WOMEN'S PREVENTIVE SERVICES**

Benefits for "Breast-feeding Support, Services and Supplies" are amended to read as follows:

Benefits will be provided for breast-feeding counseling and support services rendered by a Provider for pregnant and postpartum women. Benefits include the rental (or, at the Plan's option, the purchase) of manual or electric breast-feeding equipment.

B. **AMENDMENT RESPECTING MATERNITY SERVICES**

The *Maternity Services* section of the Certificate is amended as follows:

1. The exclusion for services provided by midwives shall no longer be applicable.
2. The following exclusion is added:

   Benefits will not be provided for any services related to elective abortion, unless the life or health of the mother is endangered.

C. **AMENDMENT RESPECTING OUT-OF-AREA SERVICES**

Your Certificate of Benefits is amended so that the provisions outlining "*Benefits for Services Outside the State of Oklahoma*", as set forth in the ***General Provisions*** section, are deleted in their entirety and replaced by the following provisions:

OUT-OF-AREA SERVICES

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

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

- **BlueCard® Program**

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

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

  – The billed charges for your Covered Services; or

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

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

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

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

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

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

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

  - **Exceptions**

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

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

D. **AMENDMENT RESPECTING RIGHT OF RECOUPMENT**

The ***General Provisions*** section of the Certificate is amended by deletion of the following sentence under the "*Plan's Right of Recoupment*" provisions:

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

E. **AMENDMENT RESPECTING RELIGIOUS EMPLOYER EXEMPTION AND ELIGIBLE ORGANIZATION ACCOMMODATION**

A certification(s) may have been provided to Blue Cross and Blue Shield of Oklahoma that your Group Health Plan is established or maintained by an organization(s) that is a "religious employer(s)" as defined in 45 C.F.R. 147.131(a), as modified or replaced, and qualifies for a religious employer exemption from the Affordable Care Act requirement to cover certain contraceptive services without cost sharing under guidelines supported by the Health Resources and Services Administration ("Religious Employer Exemption"). Provided that the Religious Employer Exemption is satisfied for your Group Health Plan, then coverage under your Group Health Plan, as set forth under "*Preventive Care Services"* in the ***Comprehensive Health Care Services*** section of your Certificate, will not include coverage for some or all of such contraceptives services (please call Customer Service at the number on the back of

your Identification Card for more information). Questions regarding the Religious Employer Exemption should be directed to your Group Administrator.

In addition, a certification(s) may have been provided to Blue Cross and Blue Shield of Oklahoma that your Group Health Plan is established or maintained by an organization(s) that is an "eligible organization(s)" as defined in 45 C.F.R. 147.131(b), as modified or replaced, and qualifies for an eligible organization accommodation with respect to the Affordable Care Act requirement to cover certain contraceptive services without cost sharing under guidelines supported by the Health Resources and Services Administration ("Eligible Organization Accommodation"). Provided that the Eligible Organization Accommodation is satisfied, coverage under your Group Health Plan, as set forth under *"Preventive Care Services"* in the ***Comprehensive Health Care Services*** section of your Certificate, will not include coverage for some or all of such contraceptives services. If you have questions regarding the certification(s), you may contact your Group Administrator. For other questions about the Eligible Organization Accommodation, you may contact Customer Service at the number on the back of your Identification Card.

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.

The above changes to your Group Health Plan are effective on the first of the following dates occurring on or after January 1, 2014:

1. **the Group Contract Date;**
2. **the Group's first Contract Date Anniversary (renewal date); or**
3. **the first Plan Year of the Group Health Plan.**

President of Blue Cross and Blue Shield of Oklahoma

BlueCross BlueShield
of Oklahoma

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AMENDMENTS RESPECTING WOMEN'S PREVENTIVE CARE SERVICES

IT IS AGREED that the Certificate of Benefits to which this amendment is issued for attachment is amended by the addition of the following provisions:

A. **AMENDMENT RESPECTING PREVENTIVE CARE SERVICES**

Preventive Care Services with respect to women are amended to include the following Covered Services when performed by BlueChoice or BlueCard Providers and will not be subject to Deductible, Copayment, Coinsurance or dollar maximums:

1. Breastfeeding Support, Services and Supplies – Benefits will be provided for breastfeeding counseling and support services rendered by a Provider for pregnant and postpartum women. Benefits include the rental (or, at the Plan's option, the purchase if it will be less expensive) of ***manual*** breast pumps, accessories and supplies.
2. Contraceptive Services – Benefits will be provided for the following contraceptive services when prescribed by a licensed Provider for women with reproductive capacity:

   - contraceptive counseling;
   - FDA-approved prescription devices and medications;
   - over-the-counter contraceptives; and
   - sterilization procedures (tubal ligation), but not including hysterectomy.

   Coverage includes contraceptives in the following categories:
   - progestin-only contraceptives;
   - combination contraceptives;
   - emergency contraceptives;
   - extended-cycle/continuous oral contraceptives;
   - cervical caps;
   - diaphragms;
   - implantable contraceptives;
   - intra-uterine devices;
   - injectables;
   - transdermal contraceptives; and
   - vaginal contraceptive devices.

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

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

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

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

B. **AMENDMENT RESPECTING EXCLUSIONS**

The exclusion of contraceptive medications or devices shown in the ***Exclusions*** section is hereby removed and replaced with the following:

- 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.

C. AMENDMENT RESPECTING CONTRACEPTIVE COVERAGE

If your Group has indicated to the Plan that it qualifies for a one-year temporary exemption or a permanent exemption with respect to the federal requirement to cover contraceptive services without cost sharing, coverage under your Group Health Plan will not include coverage for contraceptive services. Questions regarding this exemption should be directed to your Group Administrator.

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 Contract or Certificate to which this amendment is attached will remain in full force and effect.

For Contracts in effect on or after August 1, 2012, this amendment is effective on the Group Contract Date or Contract Date Anniversary.

President of Blue Cross and Blue Shield of Oklahoma

BlueCross BlueShield of Oklahoma

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AMENDMENT RESPECTING OUTPATIENT PRESCRIPTION DRUGS AND RELATED SERVICES

Effective January 1, 2012, or your Effective Date, if later, your Certificate of Benefits is amended by the addition of the following special provisions.

A. The Benefits specified in your Certificate for ***Outpatient Prescription Drugs and Related Services,*** if applicable, are amended as set forth below:

PRESCRIPTION DRUG QUANTITY/DISPENSING LIMITS

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

- **Benefit Supply Limits per Prescription Order**

  For each Coinsurance amount specified for Outpatient Prescription Drugs, you can obtain the following supply of a single Prescription Drug or other item covered under this Certificate (unless otherwise specified).

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

  – During each one-month period, up to a 34-day supply or 120 units (e.g. pills), whichever is less, for "non-maintenance" Prescription Drugs. If more than 120 units are needed to reach a 34-day supply, another Coinsurance amount will apply to each additional 120 units (or portion thereof) purchased.

  – During each three-month period, up to a 90-day supply or 360 units (e.g. pills), whichever is less for drugs designated by the Plan as maintenance Prescription Drugs. If less than a 90-day supply is ordered, the mail-order Coinsurance will still apply. If more than 360 units are needed to reach a 90-day supply, an additional mail-order Coinsurance amount will apply to each additional 360 units (or portion thereof) purchased.

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

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

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

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

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

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

EXCLUSIONS AND LIMITATIONS

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

- Drugs which by law do not require a Prescription Order from an authorized Provider (except insulin, insulin analogs, insulin pens, and prescriptive and nonprescriptive oral agents for controlling blood sugar level); and drugs, insulin or covered devices for which no valid Prescription Order is obtained.
- Devices or Durable Medical Equipment of any type (even though such devices may require a Prescription Order), such as, but not limited to, contraceptive devices, therapeutic devices, artificial appliances, or similar devices (**except** glucose meters, lancets, test strips and disposable hypodermic needles and syringes for self-administered injections.) However, coverage for prescription contraceptive devices is provided under the ***Comprehensive Health Care Services*** section of your Certificate.
- 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.
- Prescription Drugs, devices, or other Pharmacy services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States (including but not limited to,

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

- Any services provided or items furnished for which the Pharmacy normally does not charge.
- Infertility medications and fertility medications; prescription contraceptive devices or non-prescription contraceptive materials (**except** oral contraceptive medications which are Prescription Drugs). However, coverage for prescription contraceptive devices is provided under the ***Comprehensive Health Care Services*** section of this Certificate.
- Drugs required by law to be labeled: "Caution — Limited by Federal Law to Investigational Use," or Experimental drugs, even though a charge is made for the drugs.
- Prescription Drugs or devices dispensed in quantities in excess of the amounts stipulated in this ***Outpatient Prescription Drug Benefits*** section; or refills of any prescriptions in excess of the number of refills specified by the Physician or by law; or any drugs or medicines dispensed more than one year following the Prescription Order date.
- Drugs which are not approved by the U.S. Food and Drug Administration (FDA) for a particular use or purpose or when used for a purpose other than the purpose for which the FDA approval is given, except as required by law or regulation.
- Fluids, solutions, nutrients, medications (including all additives and Chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous, intramuscular (in the muscle), intrathecal (in the spine), or 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.
- 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.
- Any smoking cessation products, including those which require a Prescription Order.
- Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.
- Athletic performance enhancement drugs.

- Compounded medications. For purposes of this exclusion, "compounded medications" are substances made by mixing, reconstituting or other such acts, not in accordance with directions contained in Food and Drug Administration (FDA) approved labeling provided by the product's manufacturer and other FDA-approved manufacturer directions consistent with that labeling.
- Replacement of drugs or other items that have been lost, stolen, destroyed, or misplaced.
- Shipping, handling, or delivery charges.
- Drugs which are repackaged by anyone other than the original manufacturer.

B. The ***General Provisions*** section of your Certificate is amended so that the "PHARMACY BENEFIT ADMINISTRATION" provisions are hereby deleted and replaced by the following provisions:

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

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

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

  To help you understand how the Plan's separate financial arrangements with Participating Prescription Drug Providers work, please consider the following example:

  – Assume you have a prescription dispensed and the undiscounted amount of the Prescription Drug is $100. How is the $100 bill paid?
  – You will have to pay the Coinsurance amount set out in this Certificate.
  – However, for purposes of calculating your Coinsurance amount, the full amount of the Prescription Drug would be reduced by the discount. In our example, if the applicable discount were 20%, the $100 Prescription Drug bill would be reduced by 20% to $80 for purposes of calculating your Coinsurance amount.

- In our example, if your Coinsurance obligation is 20%, you will have to pay 20% of $80, or $16. You should note that your 20% Coinsurance amount is based upon the discounted amount of the prescription and not the full $100 bill.

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

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

The amounts received by Prime from the Plan, pharmacies, manufacturers or other third parties may be revised from time to time. Some of the amounts received by Prime may be charged each time a claim is processed (or, in some instances, requested to be processed) through Prime and/or each time a prescription is filled, and include, but are not limited to, administrative fees charged by Prime to the Plan (as described above), administrative fees charged by Prime to pharmacies, and administrative fees charged by Prime to pharmaceutical manufacturers. Currently, none of 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 pharmacy and other PBM services operate through the same entity, Prime Therapeutics LLC.

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

* * * * * * * *

Except as amended, your Certificate of Benefits remains unchanged.

PLEASE KEEP THIS NOTICE WITH YOUR CERTIFICATE OF BENEFITS FOR FUTURE REFERENCE.

President of Blue Cross and Blue Shield of Oklahoma

BlueCross BlueShield
of Oklahoma

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

AMENDMENT RESPECTING COMPLAINT/APPEAL PROCEDURE

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

A. The **"Preauthorization"** or **"Preauthorization/Precertification"** provisions are amended so that the paragraph entitled "Precertification Requests Involving Urgent Care" is hereby deleted and replaced by the following:

- **Preauthorization Requests Involving Urgent Care**

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

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

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

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

B. The **"Concurrent Review" or "Concurrent Review and Case Management"** provisions are deleted in their entirety and replaced by the following:

CONCURRENT REVIEW

Whenever it is determined that Inpatient care or an ongoing course of treatment may no longer be Medically Necessary, you, your Provider or your authorized representative may submit a request to the Plan for continued services. If you, your Provider or your authorized representative requests to extend

care beyond the approved time limit and it is a Request Involving Urgent Care, the Plan will make a determination on the request/appeal as soon as possible (taking into account medical exigencies) but no later than 72 hours after it receives the initial request, or within 48 hours after it receives the missing information (if the initial request is incomplete).

C. AMENDMENT RESPECTING COMPLAINT/APPEAL PROCEDURE

The **"Complaint/Appeal Procedures"** currently reflected in Certificate of Benefits, or in any amendment attached thereto, are hereby deleted and restated as follows:

COMPLAINT/APPEAL PROCEDURE

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

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

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

CLAIM DETERMINATIONS

When the Plan receives a Properly Filed Claim, it has authority and discretion under this Certificate to interpret and determine 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 Preauthorization, or any other determination of your Benefits made by the Plan under Certificate.

IF A CLAIM IS DENIED OR NOT PAID IN FULL

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

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

- The reasons for the determination;
- A reference to the Benefit provisions on which the determination is based, or the contractual, administrative or protocol for the determination;

- A description of additional information which may be necessary to perfect an appeal and an explanation of why such material is necessary;
- Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care Provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
- An explanation of our internal review/appeals and external review processes (and how to initiate a review/appeal or external review);
- In certain situations, a statement in non-English language(s) that the written notice of the claim denial and certain other Benefit information may be available (upon request) in such non-English language(s);
- In certain situations, a statement in non-English 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 treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;
- In the case of a denial of an Urgent Care Clinical Claim, a description of the expedited review procedure applicable to such claims. An urgent care claim decision may be provided orally, so long as a written notice is furnished to the claimant within 3 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 Benefit(s). There are three types of claims, as defined below.

- **"Urgent Care Claim"** is any pre-service request for benefit(s) that requires Preauthorization, as described in 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"** 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 appeals of Urgent Care Clinical Claims in writing. You should call us at the toll-free number listed on the back of your Identification Card as soon as possible to appeal an Urgent Care Clinical Claim.

PRE-SERVICE CLAIMS

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

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

POST-SERVICE CLAIMS

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

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

CLAIM APPEAL PROCEDURES

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

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

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

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

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

  Upon receipt of an expedited pre-service or concurrent clinical appeal, we will notify the party filing the appeal, as soon as possible, but no more than 24 hours after submission of the appeal, of all the

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

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

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

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

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

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

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

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

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

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

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

- ***Timing of Appeal Determinations***

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

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

- ***Notice of Appeal Determination***

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

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

EXTERNAL REVIEW RIGHTS

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

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

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

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

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

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

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

1215 South Boulder • P. O. Box 3283 • Tulsa, OK 74102-3283

AMENDMENTS TO THE GROUP HEALTH PLAN

IT IS AGREED that the Group Contract and the Certificate of Coverage to which this amendment is issued for attachment are amended as set forth below:

A. AMENDMENT RESPECTING DEPENDENT ELIGIBILITY

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

If the Group Health Plan contains provisions extending coverage for Dependents beyond their 26th birthday (e.g., for full-time students), then those provisions shall remain in effect. A Dependent child who is medically certified as disabled and dependent upon the Member or his/her spouse is eligible to continue coverage beyond the limiting age, provided the disability began before the child attained the age of 26.

B. AMENDMENT RESPECTING PREEXISTING CONDITION PROVISIONS

The Preexisting Condition provisions of the Group Health Plan are amended so that the Preexisting Condition Exclusion shall not apply to Subscribers under age 19.

C. AMENDMENT RESPECTING LIFETIME MAXIMUMS

The Lifetime Maximum set forth in the Schedule of Benefits, or in any amendment or endorsement to the Group Contract or Certificate of Benefits, is hereby deleted. Coverage under the Group Health Plan shall not be subject to any ***dollar*** Lifetime Maximum, including the separate ***dollar*** Lifetime Maximum previously applicable for treatment of autism and autism spectrum disorders.

D. AMENDMENT RESPECTING BENEFIT PERIOD MAXIMUMS

The Benefit Period ***dollar*** maximums shown in the Schedule of Benefits, Covered Comprehensive Health Care Services section or in any amendment or endorsement issued thereto are amended as set forth below:

1. Preventive Care Services — Any Benefit Period ***dollar*** maximum specified for Preventive Care Services shall no longer apply. This includes any separate ***dollar*** maximum applicable to mammography screening, bone density testing or prostate cancer screening.

2. Private Duty Nursing — Covered Services shall be limited to a maximum of 85 visits per Benefit Period. The Benefit Period ***dollar*** maximum is hereby removed.
3. Hospice Services — The Benefit Period ***dollar*** maximum is hereby removed.
4. Durable Medical Equipment — The Benefit Period ***dollar*** maximum is hereby removed.
5. Prosthetic Appliances — The Benefit Period ***dollar*** maximum is hereby removed.
6. Services Related to Treatment of Autism or Autism Spectrum Disorders — The Benefit Period ***dollar*** maximum is hereby removed. The age limit for treatment of autism or autism spectrum disorders is hereby removed. The following limitations shall apply:

   - **Subscribers under age six** shall be entitled to a combined maximum of 390 visits for Physical Therapy, Occupational Therapy and Speech Therapy per Benefit Period.
   - Subscribers age six and older are subject to the limitations specified under "**Outpatient Therapy Services**" as set forth in the ***Comprehensive Health Care Services*** section of this Certificate. No Benefits are provided for Outpatient Speech Therapy.

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

E. AMENDMENT RESPECTING EMERGENCY CARE SERVICES

Emergency Care Services rendered by an Out-of-Network or Non-Participating Provider shall be paid at the same Benefit level applicable to Network/Participating Providers. Any Benefit reductions for Out-of-Network Services in the form of higher Deductibles, Copayments and/or Coinsurance are hereby removed.

Notwithstanding anything in the Contract/Certificate 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 three amounts is calculated excluding any network or contracting Provider Copayment or Coinsurance imposed with respect to the Subscriber.

F. AMENDMENT RESPECTING PREVENTIVE CARE SERVICES

Benefits will be provided for the following Covered Services, and BlueChoice PPO or BlueCard Provider services will not be subject to Deductible, Copayment, Coinsurance or dollar maximums:

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.

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

The Preventive Care Services described in items 1 through 4 above may change as USPSTF, CDC and HRSA guidelines are modified. For more information, Subscribers may access the website at www.bcbsok.com or contact customer service at the toll-free number listed on their identification card.

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

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

Covered Services ***not*** included in items 1 through 4 above may be subject to Copayment, Deductible, Coinsurance and/or dollar maximums.

Covered Preventive Care Services received from Out-of-Network Providers may be subject to Copayment, Deductible and 30% Coinsurance.

The Exclusions section is amended so that any exclusion for "routine, screening or periodic physical examinations" shall not be applicable to the Preventive Care Services described above.

G. AMENDMENT RESPECTING TREATMENT OF AUTISM AND AUTISM SPECTRUM DISORDERS

Benefits for the treatment of autism and autism spectrum disorders shall no longer be limited to Subscribers under age six. However, such treatment shall be subject to the Preexisting Condition limitations of the Group Health Plan (except for Subscribers under age 19), the limitations set forth in Paragraph D, 6, above, and any other limitations set forth in the Contract/Certificate and any amendments attached thereto.

H. AMENDMENT RESPECTING MEMBER APPEAL RIGHTS

The External Review (Level III) appeals process is amended by the addition of the following provisions:

For questions or assistance regarding the right to an external review by an independent review organization, the Member may call the customer service number shown on the Identification Card. Members may also contact the Oklahoma Insurance Department at the following address:

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

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 Contract or Certificate to which this amendment is attached will remain in full force and effect.

For Contracts in effect on or after September 23, 2010, this amendment is effective on the Group Contract Date or Contract Date Anniversary.

President of Blue Cross and Blue Shield of Oklahoma

BlueCross BlueShield
of Oklahoma

1215 South Boulder • P. O. Box 3283 • Tulsa, OK 74102-3283

AMENDMENTS RESPECTING ALLOWABLE CHARGE DETERMINATIONS FOR OUT-OF-NETWORK SERVICES

IT IS AGREED that the Group Contract, Individual Conversion Contract or Certificate of Benefits to which this amendment is issued for attachment is amended by the addition of the following provisions:

A. AMENDMENT RESPECTING ALLOWABLE CHARGE FOR NON-CONTRACTING PROVIDERS

The Contract/Certificate is amended to reflect the following method for determining the Allowable Charge for Providers who do not have a Participating Provider agreement with Blue Cross and Blue Shield of Oklahoma (Non-Contracting Providers).

The Allowable Charge for Non-Contracting Providers for Covered Services will be the lesser of:

1. the Provider's billed charges; or
2. the Plan's Non-Contracting Allowable Charge.

The Non-Contracting Allowable Charge is developed from base Medicare reimbursements, excluding any Medicare adjustments using information on the claim, and adjusted by a predetermined factor established by the Plan. Such factor will not be less than 100% of the base Medicare reimbursement rate. For services for which a Medicare reimbursement rate is not available, the Allowable Charge for Non-Contracting Providers will represent an average contract rate for Network Providers adjusted by a predetermined factor established by the Plan and updated on a periodic basis. Such factor shall not be less than 100% of the average contract rate and will be updated not less than every two years. BCBSOK 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, the Member will be responsible for the difference, along with any

applicable Copayment, Coinsurance and Deductible amount. This difference may be considerable. To find out an estimate of the Plan's Non-Contracting Allowable Charge for a particular service, Members may call the customer service number shown on the back of the Blue Cross and Blue Shield of Oklahoma Identification Card.

B. **AMENDMENT RESPECTING SERVICES RECEIVED OUTSIDE THE STATE OF OKLAHOMA**

The Contract/Certificate is amended to reflect the following provisions related to the processing of "Out-of-Network" or "Non-Participating" Provider claims:

Blue Cross and Blue Shield Plans in other states are now ***required*** to determine the "Allowable Charge" for services received outside the state of Oklahoma. Because of this change, the following language is added to your Certificate:

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

The above provisions supersede any language in the Contract or Certificate, under the definition of "Allowable Charge" or in any other section of the Contract/Certificate, outlining the manner in which claims are processed for services received from Out-of-Network/Non-Participating Providers or for services received outside the state of Oklahoma.

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

The provisions of this amendment are effective as follows:

1. For Employer Group Health Plans, this amendment is effective on the first of the following dates occurring on or after January 1, 2011:
   a. the Group Contract Date;
   b. the Group's first Contract Date Anniversary (renewal date); or
   c. the first Plan Year of the Group Health Plan.
2. For Health Check coverage, this amendment is effective on the Policy Year beginning January 1, 2011, or the effective date of the Certificate to which it is issued for attachment, whichever is later.
3. For Individual Conversion Contracts, this amendment is effective on the Policy Year beginning January 1, 2011, or the effective date of the Contract to which it is issued for attachment, whichever is later.

President of Blue Cross and Blue Shield of Oklahoma

BlueCross BlueShield
of Oklahoma

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

AMENDMENT RESPECTING PREAUTHORIZATION/PRECERTIFICATION REQUIREMENTS

IT IS AGREED that the Group Contract and/or Certificate of Benefits to which this amendment is issued for attachment is amended by the addition of the following provisions:

A. The Contract/Certificate is amended to include the following definitions:

- **Intensive Outpatient Program**

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

- **Preauthorization/Precertification**

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

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

B. The Contract/Certificate is amended so that all references to the term "Precertification" shall have the same meaning as Preauthorization/Precertification as defined as above.

C. In addition to the Precertification requirements set forth in the Contract/Certificate, the following provisions shall apply:

- **Subscriber Responsibility for Preauthorization/Precertification**

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

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

- **Preauthorization Process for Psychiatric Care Services**

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

  – Psychological testing;

  – Neuropsychological testing;

  – Electroconvulsive therapy;

  – Intensive Outpatient Treatment.

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

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

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

- **Failure to Preauthorize**

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

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

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

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

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

The provisions of this amendment are effective January 1, 2012.

President of Blue Cross and Blue Shield of Oklahoma

SPECIAL NOTICE REGARDING BENEFITS FOR AUTISM AND AUTISM SPECTRUM DISORDERS

Effective on your Group's first renewal date coinciding with or next following January 1, 2010 (or your Effective Date, if later), your Certificate of Benefits is amended by the addition of the following special Benefit provisions.

- Subject to the Exclusions, conditions, and limitations of this Certificate, Benefits will be provided for ***Outpatient Medical Services*** for treatment of autism and autism spectrum disorders, in accordance with the following special provisions:

  SERVICES RELATED TO TREATMENT OF AUTISM AND AUTISM SPECTRUM DISORDERS

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

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

  – Childhood disintegrative disorder — Heller's syndrome;

  – Rett's syndrome; and

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

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

  Benefits related to treatment of autism and autism spectrum disorders are not subject to the ***Preexisting Condition Exclusion*** provisions of this Certificate.

  Benefits for treatment of autism and autism spectrum disorders are limited to Subscribers under six years of age and shall be further limited to a maximum of:

  ○ **$25,000 per Benefit Period per Subscriber; and**

  ○ **$75,000 per lifetime per Subscriber (subject to the overall lifetime maximum for *Comprehensive Health Care Services*, as set forth in this Certificate).**

- Benefits for the treatment of autism and autism spectrum disorders shall be subject to the same provisions regarding:

  – Deductible, Copayment and/or Coinsurance provisions set forth in the ***Schedule of Benefits*** for other Outpatient Medical Services; and

  – Precertification/preauthorization and utilization review mechanisms as applicable to all Covered Services under the Certificate.

- The ***Exclusions*** section of this Certificate is amended as follows:

  – The exclusion for "conditions related to autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems, mental retardation, or for Inpatient confinement for environmental change" is deleted in its entirety and replaced by the following exclusion:

For conditions related to hyperkinetic syndromes, learning disabilities, behavioral problems, mental retardation, or for Inpatient confinement for environmental change. **This exclusion *shall not* apply to the following Medically Necessary services:**

- **Physicians' services (except for neuropsychological testing) related to the diagnosis and treatment of attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD) for Subscribers age 19 and under; or**
- **Prescription Drug therapy (provided the Certificate includes Benefits for Outpatient Prescription Drugs) for treatment of ADD/ADHD in Subscribers age 19 and under.**

– The exclusion for "Speech Therapy and any related diagnostic testing" is deleted and replaced by the following exclusion:

For Speech Therapy and any related diagnostic testing, except as provided by a Hospital or Plan-approved rehabilitation facility as part of a covered Inpatient stay, or as specified in this amendment for the limited treatment of autism and autism spectrum disorders.

– The following exclusions are hereby added:

- For unspecified developmental disorders or autistic disease of childhood, except as specified in this amendment.
- For or related to applied behavior analysis.

* * * * * * * *

Except as amended, your Certificate/Booklet remains unchanged.

PLEASE KEEP THIS NOTICE WITH YOUR CERTIFICATE/BOOKLET FOR FUTURE REFERENCE.

SPECIAL NOTICE REGARDING ELIGIBILITY, COVERED SERVICES, EXCLUSIONS, GENERAL PROVISIONS AND DEFINITIONS

Your Certificate of Benefits is amended by the addition of the following special provisions. Unless otherwise specifically stated in this notice, or as required by federal or state regulation, the provisions of this notice are effective February 1, 2010, or your Effective Date, whichever is later.

- **AMENDMENT REGARDING ELIGIBLE PERSONS**

  The ***Eligibility, Enrollment, Changes & Termination*** section is amended as follows:

  You are an Eligible Person if you satisfy the eligibility requirements specified by your Employer, as set forth in the Group Contract.

- **AMENDMENT REGARDING DEPENDENT ELIGIBILITY**

  The ***Eligibility, Enrollment, Changes & Termination*** section is amended by the addition of the following special provisions under the heading "**Who Is an Eligible Dependent**":

  Coverage will continue under this Certificate for an unmarried Dependent who is unable to maintain Full-Time Student status as a result of a medically necessary leave of absence or any other change in enrollment, provided that:

  – The Dependent is enrolled on the basis of being a student at a postsecondary education institution; and

  – The Dependent was covered immediately before the first day of the medically necessary leave of absence or other change in enrollment; and

  – The Dependent child's treating Physician provides to the Plan a written certification stating that the child is suffering from a serious illness or injury and that the leave of absence or other change in enrollment is medically necessary.

  Coverage for such a Dependent may be continued under the Certificate until the date that is the earlier of:

  – One year after the first day of the medically necessary leave of absence or other change in enrollment; or

  – The date on which such coverage would otherwise terminate under the terms of the Certificate.

  The first day of the medically necessary leave of absence will be documented as the date indicated by the Physician in the written certification on which the medical leave or other enrollment change is to begin.

- **AMENDMENT REGARDING SPECIAL ENROLLMENT RELATED TO MEDICAID AND CHILD HEALTH INSURANCE PROGRAM (CHIP) COVERAGE**

  The ***Eligibility, Enrollment, Changes & Termination*** section is amended by the addition of the following special provisions:

Effective April 1, 2009, 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 under special enrollment will be effective no later than the first day of the month after the Plan receives the special enrollment request.

- **AMENDMENT REGARDING TERMINATION OF COVERAGE AND CONVERSION PRIVILEGES**

The ***Eligibility, Enrollment, Changes & Termination*** section is amended as follows:

- The termination provisions under the heading "**When Coverage under this Certificate Ends**" are amended to extend coverage from 31 days to 63 days following termination, in accordance with the following:

  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 this Certificate 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.

- The paragraph entitled, "**What We Will Pay for After Your Coverage Ends**" is deleted in its entirety and replaced by the following provisions:

  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 an 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.

– The provisions outlining your "**Conversion Privilege After Termination of Group Coverage**" are amended so that conversion privileges shall not be applicable to the following individuals:

▪ a Member who is eligible for coverage under a group having a contract with the Plan;

▪ a Dependent who is covered under any policy of benefits for hospital and surgical/medical care and services provided by an employer or group; or

▪ any Subscriber who ceases to be eligible due to cancellation of the Group Contract.

- **AMENDMENT REGARDING ORAL CHEMOTHERAPY**

  The ***Covered Comprehensive Health Care Services*** section is amended by the addition of the following special provisions under "**Outpatient Therapy Services**":

  Outpatient Therapy Services do not include oral Chemotherapy or self-injectable Chemotherapy. These Prescription Drugs may be covered under your *Outpatient Prescription Drug Benefits*, if applicable, under this Certificate.

- **AMENDMENT REGARDING OUTPATIENT THERAPY SERVICES**

  The Benefits specified in this Certificate for "**Outpatient Physical Therapy**" and "**Outpatient Occupational Therapy**" shall include Covered Services provided during a visit to the Subscriber's home, as well as visits to the Provider's office or other Outpatient visits.

- **AMENDMENT REGARDING PSYCHIATRIC CARE SERVICES**

  – The ***Covered Comprehensive Health Care Services*** section is amended by the addition of the following special provisions under "**Psychiatric Care Services**":

  ○ "Inpatient Facility Services" are restated to include the following:

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

- "Outpatient Facility and Medical Services" are restated to include the following:

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

– The ***Definitions*** section is amended by the addition of the following paragraph:

  - **PSYCHIATRIC HOSPITAL** – a Provider that is a state licensed hospital that primarily specializes in the treatment of severe Mental Illnesses and/or substance abuse disorders.
  - **RESIDENTAL TREATMENT CENTER** – a state licensed and/or state certified facility that provides a 24-hour level of residential care to patients with long-term or severe Mental Illnesses and/or substance abuse disorders. This care is medically monitored, with 24-hour Physician availability and 24-hour onsite nursing services.

- **AMENDMENT REGARDING PROSTHETIC APPLIANCES AND ORTHOTIC DEVICES**

  The Benefits specified in this Certificate for "**Prosthetic Appliances**" and "**Orthotic Devices**" are amended to include replacement appliances or devices when Medically Necessary.

- **AMENDMENT REGARDING OUTPATIENT PRESCRIPTION DRUGS AND RELATED SERVICES**

  The Benefits specified in this Certificate for "**Outpatient Prescription Drugs and Related Services**", if applicable, are amended to include the following special provisions:

  – **Brand Name Drug Exclusion**

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

  – **Pharmacy Discount Programs**

    In an effort to help offset the rising cost of Prescription Drugs, drug manufacturers may offer coupons or other drug discounts or rebates to Subscribers, which may impact the Benefits provided under this program. The total Benefits payable will not exceed the balance of the Allowable Charges remaining after all drug coupons, rebates or other drug discounts have been applied. You agree to reimburse the Plan any excess amounts for Benefits that we have paid and for which you are not eligible due to the application of drug coupons, rebates or other drug discounts.

- **AMENDMENT REGARDING EXCLUSIONS**

  The ***Exclusions*** section is amended as set forth below:

  – The following exclusions are hereby removed:

    - For drug and alcohol treatment that is not rendered in a Hospital or by a psychiatrist, psychologist, licensed clinical social worker or person with a master's degree in social work.
    - For services rendered by licensed professional counselors, marital and family therapists or counselors, or licensed drug and alcohol counselors.

- The following exclusions are hereby added:
  - 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.

- **AMENDMENT REGARDING PLAN'S RIGHT OF RECOUPMENT**

  The ***General Provisions*** section is amended by the addition of the following provision under "**Plan's Right of Recoupment**":

  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.

- **AMENDMENT REGARDING MEDICAL NECESSITY**

  The ***Definitions*** section is amended so that the definition of "Medically Necessary (or Medical Necessity)" is hereby deleted and replaced by the following definition:

  Medically Necessary (or Medical Necessity) – health care services that a Hospital, Physician, or other Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

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

* * * * * * * *

Except as amended, your Certificate remains unchanged.

PLEASE KEEP THIS NOTICE WITH YOUR CERTIFICATE FOR FUTURE REFERENCE.

BlueCross BlueShield of Oklahoma

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