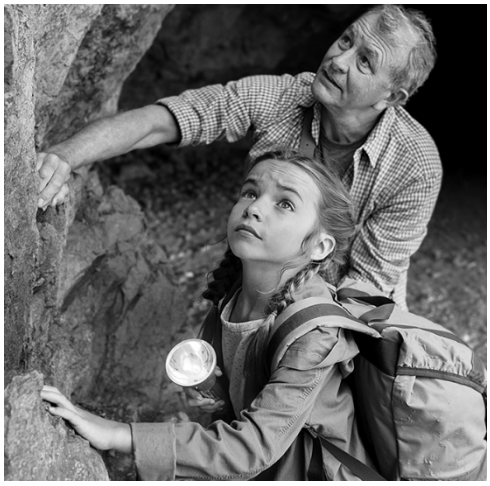
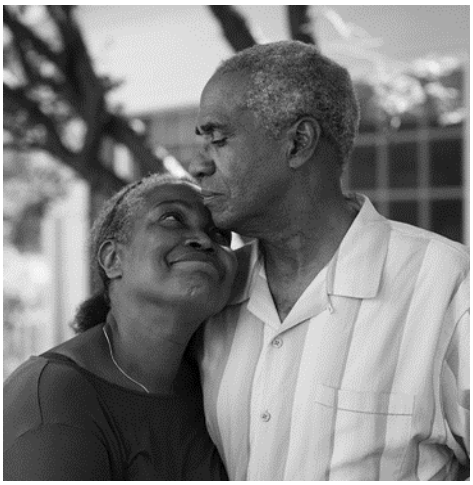
BlueCross BlueShield of Oklahoma





Your Health Care Benefits Program

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

OK-GP-PPO-27

Blue Options Bronze PPO SM 306

Blue Options PPO SM Network

Schedule of Benefits for Comprehensive Health Care Services and Outpatient Prescription Drugs and Related Services

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

COMPREHENSIVE HEALTH CARE SERVICES	
BENEFIT PERIOD	Calendar Year
NETWORK PROVIDERS	• **Blue Preferred Providers** - You will receive the highest level of Benefits if you use these Network Providers whenever possible. • **Blue Choice Providers -** You may have to share more of the cost for your Covered Services as a result of higher Copayments, Deductibles and/or Out-of-Pocket Limits that apply when you use these Network Providers. • **Out-of-Network Providers** - You may also seek care from these Providers, but your Benefits may be significantly reduced for most Covered Services, as shown in this ***Schedule of Benefits***. • **BlueCard Providers** - Your Provider network outside the state of Oklahoma made up of thousands of participating Providers nationwide. Refer to www.bcbsok.com or call a Customer Service Representative at the number shown on your Identification Card to find a Network Provider near you.
COPAYMENTS	
Emergency Room Copayment	$350 for each visit to a Hospital emergency room. This Copayment is waived if you are admitted to the Hospital through the emergency room visit. **In addition to the Copayment, the remaining Allowable Charges *are* subject to the Benefit Period Deductible and Coinsurance.**
Outpatient Surgery Copayment	• $100 for each visit to a Network Outpatient facility for Surgery. This Copayment applies to surgical procedures received in a Hospital Outpatient department, Ambulatory Surgical Facility or other freestanding Outpatient facility. • $200 for each visit to an Out-of-Network Outpatient facility for Surgery. This Copayment applies to surgical procedures received in an Out-of-Network Hospital Outpatient department, Ambulatory Surgical Facility or other freestanding Outpatient facility. **In addition to the Copayment, the remaining Allowable Charges *are* subject to the Benefit Period Deductible and Coinsurance.**
BENEFIT PERIOD DEDUCTIBLE	• **Network Provider Services –** $6,100 per Benefit Period per Subscriber, or $12,200 for all covered family members combined. • **Out-of-Network Provider Services –** $12,200 per Benefit Period per Subscriber, or $24,400 for all covered family members combined. Deductible amounts for Network Provider Services and Out-of-Network Provider Services ***do not*** cross-apply except those amounts paid for Out-of-Network Emergency Services will be applied to your Out-of-Pocket Limits for Network Provider Services.

	The Benefit Period Deductible is in addition to the Emergency Room Copayment and Outpatient Surgery Copayment, described above. The Benefit Period Deductible applies to all Covered Services, except Preventive Care Services received from a Network Provider. Preventive Care Services received from an Out-of-Network Provider are subject to Deductible, except for: – Annual mammography screening; – Annual prostate cancer screening; – Covered childhood immunizations (for Subscribers under age 19); – Any other state or federally mandated Benefits which stipulate a Deductible may not be required.
OUT-OF-POCKET LIMIT	• **Blue Preferred Provider Services** – $8,250 per Subscriber, or $16,500 for all covered family members combined. When this limit has been paid (including any Copayment and/or Deductible amounts) for Covered Services provided by Blue Preferred Network Providers during a Benefit Period, the amount of Allowable Charges covered by the Plan for such Subscriber will increase to 100% during the remainder of the Benefit Period for Covered Services received from Blue Preferred Network Providers. • **Blue Choice Provider Services** – $8,500 per Subscriber, or $17,000 for all covered family members combined. When this limit has been paid (including any Copayment and/or Deductible amounts) for Covered Services provided by Blue Choice Network Providers during a Benefit Period, the amount of Allowable Charges covered by the Plan for such Subscriber will increase to 100% during the remainder of the Benefit Period for Covered Services received from Blue Choice Network Providers. • **Out-of-Network Provider Services** – Unlimited. Out-of-Pocket Limits for Network Provider Services and Out-of-Network Provider Services ***do not*** cross-apply except those amounts paid for Out-of-Network Emergency Services will be applied to your Out-of-Pocket Limits for Network Provider Services. This Out-of-Pocket Limit does not include any of the following: • Services, supplies or charges limited or excluded by this Certificate; • Expenses not covered because a Benefit maximum has been reached; • Any penalty incurred due to your failure to follow the Plan's requirements for Prior Authorization, as set forth in the Certificate.
BENEFIT PERCENTAGE AMOUNT	The following chart shows the percentage of Allowable Charges covered by this Certificate through payments and/or contractual arrangements with Providers. These percentages apply only after your Deductibles and/or Copayment amounts have been satisfied. **NOTE: Any services classified as "Preventive Care Services" are paid at 100% of the Allowable Charge and are not subject to Deductibles, Copayments and/or Coinsurance, provided such services are received from Network Providers.**

COVERED SERVICES **(Subject to the *Comprehensive Health Care Services* section)**			
	BENEFIT PERCENTAGE OF ALLOWABLE CHARGES COVERED BY THE PLAN		
	Blue Preferred & BlueCard Provider Services	**Blue Choice Provider Services**	**Out-of-Network Provider Services**
PREVENTIVE CARE SERVICES			
Annual Mammography Screening	100%	100%	100%
Covered Childhood Immunizations	100%	100%	100%
All Other Covered Preventive Care Services	100%	100%	70%
EMERGENCY CARE SERVICES *See the Certificate for details regarding "Emergency Care Services".*	70%	70%	70%
THE FOLLOWING BENEFIT PERCENTAGES APPLY TO SERVICES THAT ARE NOT CLASSIFIED AS PREVENTIVE CARE SERVICES OR EMERGENCY CARE SERVICES, AS DETERMINED BY THE PLAN			
All Inpatient services and certain Outpatient services are subject to Prior Authorization approval from the Plan. See the Certificate for details regarding "Prior Authorization" requirements.			
HOSPITAL SERVICES	70%	60%	50%
SURGICAL/MEDICAL SERVICES	70%	60%	50%
OUTPATIENT DIAGNOSTIC SERVICES	70%	60%	50%
OUTPATIENT THERAPY SERVICES Maximum of 25 Outpatient visits for Physical Therapy, Occupational Therapy, Speech Therapy and Manipulative Therapy (combined) per Benefit Period*, except for services associated with treatment of Mental Health and Substance Use Disorders, as specified in this Certificate. **Separate 25-visit maximums will apply to Outpatient Rehabilitation Care and Outpatient Habilitation Care.* ***You must obtain Prior Authorization approval from the Plan before you receive Outpatient Dialysis Treatment from an Out-of-Network Provider. See the Certificate for details regarding "Prior Authorization" requirements.*	70%	60%	50%**
MATERNITY SERVICES	70%	60%	50%
MASTECTOMY AND RECONSTRUCTIVE SURGICAL SERVICES	70%	60%	50%
HUMAN ORGAN, TISSUE AND BONE MARROW TRANSPLANT SERVICES	70%	60%	50%
AMBULATORY SURGICAL FACILITY SERVICES	70%	60%	50%
SERVICES RELATED TO TREATMENT OF AUTISM AND AUTISM SPECTRUM DISORDERS	70%	60%	50%
PSYCHIATRIC CARE SERVICES	70%	60%	50%

COVERED SERVICES (Subject to the *Comprehensive Health Care Services* section)			
	BENEFIT PERCENTAGE OF ALLOWABLE CHARGES COVERED BY THE PLAN		
	Blue Preferred & BlueCard Provider Services	**Blue Choice Provider Services**	**Out-of-Network Provider Services**
AMBULANCE SERVICES	70%	70%	70%
PRIVATE DUTY NURSING SERVICES 85-visit maximum per Benefit Period	70%	60%	50%
REHABILITATION CARE AND HABILITATION CARE 30-day maximum per Benefit Period for Inpatient care *Separate 30-day maximums will apply to Inpatient Rehabilitation Care and Inpatient Habilitation Care.*	70%	60%	50%
SKILLED NURSING FACILITY SERVICES 30-day maximum per Benefit Period	70%	60%	50%
HOME HEALTH CARE SERVICES 30-visit maximum per Benefit Period	70%	60%	50%
HOSPICE SERVICES	70%	60%	50%
DENTAL SERVICES FOR ACCIDENTAL INJURY	70%	60%	50%
DIABETES EQUIPMENT, SUPPLIES AND SELF-MANAGEMENT SERVICES	70%	60%	50%
SERVICES RELATED TO CLINICAL TRIALS	70%	60%	50%
DURABLE MEDICAL EQUIPMENT **For Durable Medical Equipment and supplies obtained from an Out-of-Network Provider, either because your Provider deemed it necessary that you receive it within twenty-four (24) hours, or because there wasn't a Network Provider within fifteen (15) miles of your home address, the cost-sharing requirements will be the same as if they were obtained In-Network.*	70%	60%	50%*
PROSTHETIC APPLIANCES	70%	60%	50%
ORTHOTIC DEVICES Maximum of 15 per Benefit Period	70%	60%	50%
WIGS OR OTHER SCALP PROSTHESES Maximum of One per Benefit Period	70%	60%	50%
ALL OTHER COVERED SERVICES	70%	60%	50%

OUTPATIENT PRESCRIPTION DRUGS AND RELATED SERVICES

The Drug List shows the coverage tier for Covered Services:

- **Tier 1 –** includes mostly Generic Drugs (Preferred) and may contain some brand-name Prescription Drugs.
- **Tier 2 –** includes mostly Generic Drugs (Non-Preferred) and may contain some brand-name Prescription Drugs.
- **Tier 3 –** includes mostly Brand Drugs (Preferred) and may contain some Generic Drugs.
- **Tier 4 –** includes mostly Brand Drugs (Non-Preferred) and may contain some Generic Drugs.
- **Tier 5 –** includes mostly Specialty Drugs (Preferred) and may contain some Generic Drugs.
- **Tier 6 –** includes mostly Specialty Drugs (Non-Preferred) and may contain some Generic Drugs.

BENEFIT PERIOD	Calendar Year
DEDUCTIBLE	• Your Benefits for Outpatient Prescription Drugs and related services purchased at a Participating Pharmacy or Specialty Network Pharmacy are subject to the Benefit Period Deductible for "Network Provider Services" set forth in the ***Schedule of Benefits for Comprehensive Health Care Services.*** • Your Benefits for Outpatient Prescription Drugs and related services purchased at an Out-of-Network Pharmacy or any Pharmacy other than a Specialty Network Pharmacy are subject to the Benefit Period Deductible for "Out-of-Network Provider Services" set forth in the ***Schedule of Benefits for Comprehensive Health Care Services.***
OUT-OF-POCKET LIMIT	• Your Benefits for Outpatient Prescription Drugs and related services purchased at a Participating Pharmacy or Specialty Network Pharmacy are subject to the Out-of-Pocket Limit for "Network Provider Services" set forth in the ***Schedule of Benefits for Comprehensive Health Care Services.*** • Your Benefits for Outpatient Prescription Drugs and related services purchased at an Out-of-Network Pharmacy or any Pharmacy other than a Specialty Network Pharmacy are subject to the Out-of-Pocket Limit for "Out-of-Network Provider Services" set forth in the ***Schedule of Benefits for Comprehensive Health Care Services.***
COPAYMENT/COINSURANCE	The Copayment/Coinsurance amount applicable to each Prescription Order is set forth below.

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

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

- You are responsible for 50% of Allowable Charges, plus the applicable Copayment or Coinsurance shown below. Only the Copayment or Coinsurance will accumulate toward satisfaction of your Out-of-Network Benefit Period Deductible or Out-of-Pocket Limit; and
- In addition, to your Copayment and/or Coinsurance amounts, you will be responsible for the cost difference, if any, between the Pharmacy's billed charges and the Allowable Charge determined by the Plan.

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

Certain Covered Drugs may be available at no cost through a Participating Pharmacy for the following categories of medication: severe allergic reactions, hypoglycemia, opioid overdoses and nitrates. For further information, call the number on the back of your Identification Card.

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

	Copayment/Coinsurance Amounts per Prescription Order For Which You Are Responsible, after the Benefit Period Deductible		
Retail Pharmacy Program (Up to a 30-Day Supply)	**Preferred Participating Pharmacy**	**Participating Pharmacy**	**Out-of-Network Pharmacy[1]**
Tier 1	10% Coinsurance	20% Coinsurance	20% Coinsurance plus 50% of Allowable Charges
Tier 2	10% Coinsurance	20% Coinsurance	20% Coinsurance plus 50% of Allowable Charges
Tier 3	20% Coinsurance	30% Coinsurance	30% Coinsurance plus 50% of Allowable Charges
Tier 4	30% Coinsurance	40% Coinsurance	40% Coinsurance plus 50% of Allowable Charges

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

	Copayment/Coinsurance Amounts per Prescription Order For Which You Are Responsible, after the Benefit Period Deductible		
Extended Prescription Drug Supply Program (Up to a 90-Day Supply)	**Quantity Dispensed**	**Participating Extended Supply Retail Pharmacy**	**Any Pharmacy other than a Participating Extended Supply Retail Pharmacy**
Tier 1	1 to 90 days	10% Coinsurance	Not Covered
Tier 2	1 to 90 days	10% Coinsurance	Not Covered
Tier 3	1 to 90 days	20% Coinsurance	Not Covered
Tier 4	1 to 90 days	30% Coinsurance	Not Covered

	Copayment/Coinsurance Amounts per Prescription Order For Which You Are Responsible, after the Benefit Period Deductible		
Mail-Order Pharmacy Program (Up to a 90-Day Supply)	**Quantity Dispensed**	**Participating Mail-Order Pharmacy**	**Any Pharmacy other than a Participating Mail-Order Pharmacy**
Tier 1	1 to 90 days	10% Coinsurance	Not Covered
Tier 2	1 to 90 days	10% Coinsurance	Not Covered
Tier 3	1 to 90 days	20% Coinsurance	Not Covered
Tier 4	1 to 90 days	30% Coinsurance	Not Covered

	Copayment/Coinsurance Amounts per Prescription Order For Which You Are Responsible, after the Benefit Period Deductible	
Specialty Pharmacy Program (30-Day Supply)[2]	**Specialty Network Pharmacy**	**Any Pharmacy other than a Specialty Network Pharmacy[1]**
Tier 5	40% Coinsurance	40% Coinsurance plus 50% of Allowable Charges
Tier 6	50% Coinsurance	50% Coinsurance plus 50% of Allowable Charges

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

[2.] Coverage for Specialty Drugs are limited to a 30-day supply. However, some Specialty Drugs have FDA approved dosing regimens exceeding the 30-day supply limits and may be allowed greater than a 30-day supply. Cost share will be based on day supply (1-30-day supply, 31-60-day supply, 61-90-day supply) dispensed.

Brand Name Drug Selection

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

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

Prescription Drug List

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

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Notice(s)

Certificate

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

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

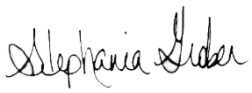
Your Group has Contracted with **Blue Cross and Blue Shield of Oklahoma** (called the Plan, we, us, or our) to provide the Benefits described in this Certificate. Blue Cross and Blue Shield of Oklahoma, having issued a Group Contract to the Group, certifies that all persons who have:

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

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

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

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



President of Blue Cross and Blue Shield of Oklahoma

Your Subscriber Identification Number:

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

Introduction

Your HSA 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 as HSA to cover "qualified medical expenses" not covered under this Certificate.

If you elect to take full advantage of the HSA 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 program, you will be given information 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 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 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

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

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

YOUR PARTICIPATING PROVIDER NETWORK

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

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

HOW YOUR COVERAGE WORKS

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

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

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

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

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

If you pay for Medically Necessary Covered Services and do not use your insurance, you may still be able to receive credit towards your in-network or out-of-network Deductible, and/or your in-network or out-of-network Out-of-Pocket Limit, if:

- Your Provider does not submit a claim to Blue Cross and Blue Shield of Oklahoma;

- The amount you paid your Provider is less than the average Allowed Amount that Blue Cross Blue Shield of Oklahoma pays for that Covered Service, and
- You submit a completed claim form with an itemized receipt and proof of payment. Please visit www.bcbsok.com for more information.

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

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

COST-SHARING FEATURES OF YOUR COVERAGE

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

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

SELECTING A PROVIDER

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

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

THE BLUECARD® PROGRAM

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

- **Finding a Physician or Hospital**

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

- **Available Care Coast to Coast**

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

- **Remember to Always Carry the BlueCard**

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

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

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

HOW THE BLUECARD PROGRAM WORKS

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

YOUR PRESCRIPTION DRUG PROGRAM

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.

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

HOW YOUR PRESCRIPTION DRUG PROGRAM WORKS

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

NOTE: Prescription Drugs must be listed on the Drug List to be covered under this Certificate unless coverage is specifically provided elsewhere in this Certificate and/or is required by applicable law or regulation. Please refer to the Plan's website at www.bcbsok.com for a list of Covered Drugs.

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

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

UTILIZATION MANAGEMENT

Utilization management may be referred to as Medical Necessity review, utilization review (UR) or medical management reviews. A Medical Necessity review for a procedure/service, Inpatient admission and length of stay is based on BCBSOK Medical Policy and/or level of care review criteria. Medical Necessity reviews may occur prior to services rendered, during the course of care, or after care has been completed.

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

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

PRIOR AUTHORIZATION

Prior Authorization establishes in advance the Medical Necessity or Experimental/Investigational nature of certain care and services covered under this Plan. It ensures that the care and services described below for which you have obtained Prior Authorization will not be denied on the basis of Medical Necessity or Experimental/Investigational.

If Prior Authorization is required, the 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. BCBSOK recommends you confirm with your Provider if Prior Authorization has been obtained.

PRIOR AUTHORIZATION RESPONSIBILITY

PARTICIPATING PROVIDER (IN-NETWORK) PRIOR AUTHORIZATION

Your Network Provider is responsible for obtaining Prior Authorization in those circumstances where authorization may be required.

For additional information about Prior Authorization for services outside of our service area, see the section entitled, "The BlueCard® Program" in ***General Provisions***.

NOTE: Providers that Contract with other Blue Cross and Blue Shield Plans are not familiar with the Prior Authorization requirements of BCBSOK. Unless a Provider Contracts directly with BCBSOK as a Participating Provider, the Provider is not responsible for being aware of this Plan's Prior Authorization requirements, except as described in the section "The BlueCard® Program" in ***General Provisions.***

NON-PARTICIPATING PROVIDER (OUT-OF-NETWORK) PRIOR AUTHORIZATION

If any Provider outside of Oklahoma (except for those Contracting as Network Providers directly with BCBSOK) or any Out-of-Network Provider recommends an Admission or a service that requires Prior Authorization, the Provider is not obligated to obtain the Prior Authorization for you. In such cases, it is your responsibility to ensure that Prior Authorization is obtained. If authorization is not obtained before services are received, you may be entirely

responsible for the charges if determined to not be Medically Necessary. If the service is determined to be Medically Necessary, Out-of-Network Benefits will apply. The Provider may call on your behalf, but it is your responsibility to ensure that the Plan is called.

To determine if a specific service or category requires Prior Authorization, visit our website at https://www.bcbsok.com/find-care/utilization-management for the required Prior Authorization list, which is updated when new services are added or when services are removed. You can also call BCBSOK Customer Service at the toll-free number on the back of your Identification Card.

INPATIENT ADMISSIONS

Your Provider may need to obtain Prior Authorization from the Plan for an Inpatient admission if Inpatient admissions are identified as needing a Prior Authorization. In the case of an elective Inpatient admission, if services require an authorization, it is recommended that the call for Prior Authorization should be made at least two working days before you are admitted unless it would delay Emergency Care. In an emergency, it is recommended that Prior Authorization should take place within two working days after admission, or as soon thereafter as reasonably possible.

Your Network Provider is required to obtain Prior Authorization for any Inpatient Admissions that may require Prior Authorization.

If the Physician or Provider of services is not a Network Provider then you, your Physician, Provider of services, or an authorized representative should obtain Prior Authorization by the Plan by calling one of the toll-free numbers shown on the back of your Identification Card. The call should be made between 7:00 a.m. and 6:00 p.m., Central Time, on business days. After business hours or on weekends, please call the toll-free number listed on the back of your Identification Card. Your call will be recorded and returned the next business day. A benefits management nurse will follow up with your Provider's office. All timelines for Prior Authorization requirements are provided in keeping with applicable state and federal regulations**.**

In-Network Benefits will be available if you use a Network Provider or Network Specialty Care Provider. If you elect to use Out-of-Network Providers for services and supplies available In-Network, Out-of-Network Benefits will be paid.

However, if care is not reasonably available from Network Providers as defined by applicable law, and BCBSOK authorizes your visit to an Out-of-Network Provider to be covered at the In-Network Benefit level **prior to the visit**, In-Network Benefits will be paid; otherwise, Out-of-Network Benefits will be paid.

When Prior Authorization of an Inpatient admission is obtained, a length-of-stay is assigned. Your Provider may seek an extension for the additional days if you require a longer stay. Benefits will not be available for room and board charges for medically unnecessary days. For more information regarding lengths of stay, refer to the **Length of Stay/Service Review** subsection.

For Behavioral Health Inpatient Admissions, please see **Contacting Behavioral Health** Section below.

Prior Authorization not Required for Maternity Care and Treatment of Breast Cancer Unless Extension of Minimum Length of Stay Requested

Your Plan is required to provide a minimum length of stay in a Hospital facility for the following:

- Maternity Care
  - 48 hours following an uncomplicated vaginal delivery;

- 96 hours following an uncomplicated delivery by caesarean section.

- Treatment of Breast Cancer
  - 48 hours following a mastectomy;
  - 24 hours following a lymph node dissection.

You or your Provider will not be required to obtain Prior Authorization from BCBSOK for a length of stay less than 48 hours (or 96 hours) for Maternity Care or less than 48 hours (or 24 hours) for Treatment of Breast Cancer. If you require a longer stay, you, your authorized representative, or your Provider must seek an extension for the additional days by obtaining Prior Authorization from BCBSOK.

OUTPATIENT SERVICE REVIEW

If Prior Authorization is required, the 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. BCBSOK recommends you confirm with your Provider if Prior Authorization has been obtained.

There may be general categories of Covered Services that require Prior Authorization.

To determine if a specific service or category requires Prior Authorization, visit our website at https://www.bcbsok.com/find-care/utilization-management for the required Prior Authorization list, which is updated when new services are added or when services are removed. You can also call Customer Service at the toll-free number on the back of your Identification Card.

For Behavioral Health Outpatient Service review, please see **Contacting Behavioral Health** Section below.

- **Failure to Obtain Prior Authorization**

  If the Subscriber does not obtain Prior Authorization for **Out-of-Network Inpatient services,** 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 other Outpatient services requiring Prior Authorization:

  – 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.

  To determine if a specific service or category requires Prior Authorization, visit our website at https://www.bcbsok.com/find-care/utilization-management for the required Prior Authorization list, which is updated when new services are added or when services are removed. You can also call Customer Service at the toll-free number on the back of your Identification Card.

- **Response to Prior Authorization Requests**

  The Plan will provide a written response to your Prior Authorization request within 7 days of obtaining all necessary information to make the decision. 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 7-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 7-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 of obtaining all necessary information to make the decision. If you fail to provide sufficient information, 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.

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 a letter to you, your Physician, Behavioral Health Practitioner and/or Hospital or facility with a determination on the approved length of service or length of stay.

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 within 72 hours of receipt of the request.

CONTACTING BEHAVIORAL HEALTH

You, your Physician or Provider of services or your authorized representative may contact the Plan for a Prior Authorization by calling the toll-free number shown on the back of your Identification Card and following the prompts to the Behavioral Health Unit. During regular business hours (8:00 a.m. and 6:00 p.m., Central Time, on business days), the caller will be routed to the appropriate behavioral health clinical team for review. Residential treatment and Outpatient requests should be requested during regular business hours. After 6:00 p.m., on weekends,

and on holidays, the same behavioral health line is answered by clinicians available for acute Inpatient reviews only.

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

ALLOWABLE CHARGE

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

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

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

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

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

The Non-Contracting Allowable Charge is developed from base Medicare reimbursements, excluding any Medicare adjustments using information on the claim, and adjusted by a predetermined factor established by the Plan. Such factor will not be less than 60% of the base Medicare reimbursement rate. However, in no event will the reimbursement exceed 90% of the lowest amount the Plan would have paid a Network Provider for the same services.

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

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

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

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

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

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

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

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

AMENDMENTS

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

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

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

IDENTIFICATION CARD

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

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

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

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

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

DESIGNATING AN AUTHORIZED REPRESENTATIVE

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

QUESTIONS

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

Or you can write to:

Blue Cross and Blue Shield of Oklahoma

PO Box 655924
Dallas, TX 75265-5924

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

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

Eligibility, Enrollment, Changes & Termination

This section tells:

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

WHO IS AN ELIGIBLE PERSON

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

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

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

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

WHO IS AN ELIGIBLE DEPENDENT

An Eligible Dependent is defined as:

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

  A Dependent child who is medically certified as disabled and dependent upon the Member or their spouse or Domestic Partner (provided the Group covers Domestic Partners) is eligible to continue coverage beyond the limiting age, provided the disability began before the child attained the age of 26.

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

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

APPLYING FOR COVERAGE

You may apply for coverage in a Group Health Plan for yourself and/or your Dependents.

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

You may enroll in or change Group Health Plans for yourself and/or your Dependents during one of the following enrollment periods.

INITIAL AND ANNUAL OPEN ENROLLMENT PERIODS/EFFECTIVE DATE OF COVERAGE

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

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

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

SPECIAL ENROLLMENT PERIODS/EFFECTIVE DATE OF COVERAGE

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

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

Special Enrollment Events:

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

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

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

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

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

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

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

- Legal separation, divorce, death, or dissolution of a Domestic Partnership (if applicable);
- Loss of Dependent status, such as attaining the limiting age to be eligible as a Dependent child under this Certificate;
- Termination of employment, for any reason other than your gross misconduct, reduction in the number of hours of employment, or loss of coverage due to a policy no longer offering Benefits to the class of similarly situated individuals that includes you and/or your Dependents;
- Loss of coverage through an HMO in the individual market because you and/or your Dependents no longer reside, live, or work in the HMO service area;
- Loss of coverage through an HMO or other arrangement in the group market because you and/or your Dependents no longer reside, live, or work in the HMO service area, and no other coverage is available to you and/or your Dependents; or
- You incur a claim that would meet or exceed a lifetime limit on all Benefits.

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

Your application for special enrollment must be received by the Plan within 31 days following the loss of other coverage.

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

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

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

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

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

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

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

Coverage resulting from any of the "Special Enrollment Events" outlined above is contingent upon timely completion of the application and remittance of the appropriate premiums in accordance with the guidelines as established by the Plan.

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

NOTIFICATION OF ELIGIBILITY CHANGES

It is the Subscriber's responsibility to notify the Plan, of any change to a Subscriber's name or address. An address change may result in Benefit changes for you and your Dependents if you move out of the Plan's Network Service Area. You may call Customer Service at the number shown on your Identification Card or visit our website at www.bcbsok.com.

QUALIFIED COURT ORDERS FOR MEDICAL COVERAGE FOR DEPENDENT CHILDREN

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

The order must include specific information such as:

- your name and address;
- the name and address of any child covered by the order;

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

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

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

DELETING A DEPENDENT

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

COBRA CONTINUATION COVERAGE

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

COBRA Continuation Coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a Qualifying Event. Specific Qualifying Events are listed later in this Certificate. After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a qualified beneficiary. You, your spouse, and Dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, qualified beneficiaries who elect COBRA Continuation Coverage must pay for COBRA Continuation Coverage.

- **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.

  If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of one or more of the following Qualifying Events:

  – Your hours of employment are reduced.

  – Your employment ends for any reason other than your gross misconduct.

  If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because of one or more of the following Qualifying Events:

  – Your spouse dies

  – Your spouse's hours of employment are reduced

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

– Your spouse's employment ends for any reason other than their gross misconduct.

– Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both).

– You become divorced or legally separated from your spouse.

Your Dependent children will become qualified beneficiaries if they lose coverage under the Plan because of one or more of the following Qualifying Events:

– The parent-employee dies.

– The parent-employee's hours of employment are reduced.

– The parent-employee's employment ends for any reason other than his or her gross misconduct.

– The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both).

– The parents become divorced or legally separated.

– The child stops being eligible for coverage under the Plan as a Dependent child.

If the Plan provides health care coverage to retired employees, the following applies:

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to your Employer, and that bankruptcy results in the loss of coverage of any retired Employee covered under the Plan, the retired Employee will become a qualified beneficiary. The retired Employee's spouse, surviving spouse, and Dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

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

– Your divorce or legal separation; or

– Your Dependent child ceasing to be an Eligible Dependent under the Plan; or

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

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

- **Election of Continuation Coverage**

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

  - the date the Qualifying Event would cause you or your Eligible 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 for any reason other than your gross misconduct or reduction in working hours;

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

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

or

- 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 non-disabled family members who are entitled to COBRA Continuation Coverage.

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

- **Multiple Qualifying Events**

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

  This extension may be available to your spouse and any Dependent children getting COBRA Continuation Coverage if you:

  – Die

  – Become entitled to Medicare benefits (under Part A, Part B, or both).

  – Get divorced or legally separated.

  – If your covered Dependent child stops being eligible under the Plan as a Dependent child.

  This extension is only available if the second Qualifying Event would have caused the spouse or Dependent child to lose coverage under the Plan had the first Qualifying Event not occurred.

- **Special TAA/ATAA Election Period**

  An Employee who loses their 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 for any reason other than your gross misconduct.

  Keep your Employer informed of address changes. To protect your family's rights, let your Employer know about any changes in addresses of family members. You should also keep a copy for your records, of any notices you send your Employer.

Contact your Employer for the name, address, and telephone number of the party responsible for administering your COBRA Continuation Coverage.

WHEN COVERAGE UNDER THIS CERTIFICATE ENDS

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

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

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

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

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

WHAT WE WILL PAY FOR AFTER YOUR COVERAGE ENDS

- If your coverage terminates for any reason under a Group Health Plan that is not subject to COBRA Continuation Coverage, Benefits under this Certificate will end on the Effective Date and time of such termination. However, termination will not deprive you of any Benefits to which you would otherwise be entitled for Covered Services incurred during the course of a Hospital confinement that began before the date and time of termination. Benefits will be provided only for a period of time which is the lesser of:
  - a period of time equal to the length of time you were covered under this Certificate; or
  - the duration of the Hospital confinement; or
  - 90 days following termination of coverage; or
  - the date you become entitled to similar insurance through some other source.
- If your coverage ends because the Member terminates employment, or because the Group itself is terminated, Benefits under this Certificate will end on the Effective Date and time your coverage is terminated, except as provided below:
  - In the event the Group Health Plan is not subject to COBRA Continuation Coverage, a Subscriber who was insured under this Certificate for six months prior to the date coverage is terminated will be entitled to an extension of Benefits under this Certificate if:
    - Covered Services are incurred due to illness or injury because of which the Subscriber is Totally Disabled at the date and time such coverage is terminated; or
    - the Subscriber has not completed a plan of surgical treatment (including Maternity Care and delivery expenses) which began prior to the date and time of such termination of coverage.
  - Coverage for the extension of Benefits shall be limited to a period which is the lesser of:
    - the duration of the uninterrupted existence of such Total Disability or completion of a plan of surgical treatment; or
    - the payment of maximum Benefits; or
    - six months following the date and time of termination of coverage.
- Your premiums must be submitted to the Plan during the period of the extension of Benefits and will be the same premiums which would have been charged for the coverage provided under this Certificate had termination not occurred.
- The Plan shall have no liability for any Benefits for Covered Services incurred after the termination of this Certificate, except as provided above.
- Benefits are not provided, even if Prior Authorization was received from the Plan, after a Subscriber's coverage under this Certificate is terminated.

TRANSFERS OUT OF THE NETWORK SERVICE AREA

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

WHEN YOU TURN AGE 65

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

Your coverage may include:

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

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

WHEN YOU RETIRE

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

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

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

Comprehensive Health Care Services

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

Coverage of items and services provided to you is subject to Blue Cross and Blue Shield of Oklahoma policies and guidelines, including, but not limited to, medical, medical management, utilization or clinical review, utilization management, and clinical payment and coding policies, which are updated throughout the Plan year. These policies are resources utilized by Blue Cross and Blue Shield of Oklahoma when making coverage determinations and lay out the procedure and/or 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 payment and coding policies are intended to ensure accurate documentation for services performed and require all Providers to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act ("HIPAA") approved code sets. Under the clinical payment and coding policies, claims are required to be coded correctly according to industry standard coding guidelines including, but not limited to: Uniform Billing ("UB") Editor, American Medical Association ("AMA"), Current Procedural Terminology ("CPT®"), CPT® Assistant, Healthcare Common Procedure Coding System ("HCPCS"), ICD-10 CM and PCS, National Drug Codes ("NDC"), Diagnosis Related Group ("DRG") guidelines, Centers for Medicare and Medicaid Services ("CMS") National Correct Coding Initiative ("NCCI") Policy Manual, CCI table edits and other CMS guidelines. Coverage for Covered Services is subject to the code edit protocols for services/procedures billed and claim submissions are subject to applicable claim review which may include, but is not limited to, review of any terms of benefit coverage, Provider Contract language, medical and medical management policies, utilization or clinical review or utilization management policies, reimbursement and coding policies as well as coding software logic, including but not limited to lab management or other coding logic or edits.

Any line on the claim that is not correctly coded and is not supported with accurate documentation (where applicable) may not be included in the covered charge and will not be eligible for payment by the Plan. The clinical payment and coding policies apply for purposes of coverage regardless of whether the Provider rendering the item or service or submitting the claim is participating or non-participating. The most up-to-date medical policies 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.

PREVENTIVE CARE SERVICES

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

1. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF");
2. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved;
3. Evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") for infants, children, and adolescents; and
4. With respect to women, such additional preventive care, and screenings, not described in item 1 above, as

provided for in comprehensive guidelines supported by the HRSA. Such services will include the following:

NOTE: The services listed below may include requirements pursuant to state regulatory mandates and are to be covered at no cost to the Member.

- Breast-feeding Support, Services and Supplies – Benefits will be provided for breast-feeding counseling and support services rendered by a Provider for pregnant and postpartum women. In addition, Benefits are provided for the rental of Hospital grade breast pumps (not to exceed the total cost) or purchase of manual or electric grade breast pumps, including breast pump supplies and breast milk storage supplies, with a written prescription from a Provider, and are not subject to Deductible, Coinsurance, Copayment or Benefit maximums when received from a Network Provider. Benefits for electric grade breast pumps are limited to one per Benefit Period.
- Contraceptive Services – Benefits will be provided for the following contraceptive services when prescribed by a licensed Provider for women with reproductive capacity:
  - contraceptive counseling;
  - FDA-approved prescription devices and medications;
  - over-the-counter contraceptives; and
  - sterilization procedures (including, but not limited to, tubal ligation), but not including hysterectomy.

  Coverage includes contraceptives in the following categories:
  - progestin-only contraceptives;
  - combination contraceptives;
  - emergency contraceptives;
  - extended cycle/continuous oral contraceptives;
  - cervical caps;
  - diaphragms;
  - implantable contraceptives;
  - intra-uterine devices;
  - injectables;
  - transdermal contraceptives;
  - condoms; and
  - vaginal contraceptive devices.

NOTE: Prescription contraceptive medications are covered under the ***Outpatient Prescription Drugs and Related Services*** section of your Certificate, *if applicable*.

The contraceptive drugs and devices listed above may change as FDA guidelines are modified. Deductible, Copayment and/or Coinsurance amounts will not apply to FDA-approved contraceptive drugs and devices on the Contraceptive Drug List. To determine if a specific drug is on the Contraceptive Drug List, you may access the website at www.bcbsok.com or contact Customer Service at the toll-free number on your Identification Card.

Preventive Drugs (including both prescription and over-the-counter products) that meet the Preventive recommendations outlined above and that are listed on the No-Cost Preventive Drug List (to be implemented in the quantities and within the time period allowed under applicable law) will be covered and will not be subject to any

Deductible, Copayment, Coinsurance or dollar maximum when obtained from a Participating Pharmacy. Drugs on the No-Cost Preventive Drug List that are obtained from a non-Participating Pharmacy, may be subject to Deductible, Copayment, Coinsurance, or dollar maximums, if applicable.

A copay waiver can be requested for Drugs or immunizations that meet the Preventive recommendations outlined above that are not on the No-Cost Preventive Drug List.

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

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

For purposes of this Benefit, the current recommendations of the USPSTF regarding breast cancer screening and mammography and prevention will be considered the most current.

Preventive Care Services will be implemented in the quantities and within the time periods allowed under applicable law. The Preventive Care Services described in items 1 through 4 above may change as the USPSTF, CDC, and HRSA guidelines are modified. For more information you may access the website at www.bcbsok.com or contact Customer Service at the toll-free number listed on your Identification Card.

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

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

Examples of Covered Services included are: (1) routine annual physicals, including immunizations, well-child care, cancer screening mammograms, annual routine obstetrical/gynecological examinations, bone density tests; and screening for prostate cancer and colorectal cancer; (2) tobacco use counseling and interventions (including a screening for tobacco use, counseling and FDA-approved tobacco cessation medications); and (3) healthy diet counseling and obesity screening/counseling.

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

Examples of covered immunizations included are COVID-19, Diphtheria, Haemophilus influenzae type b, Hepatitis B, Measles, Mumps, Pertussis, Polio, Rubella, Tetanus, Varicella and any other immunization that is required by law for a child. Allergy injections are not considered immunizations under this Benefit provision.

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

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

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

Related Services").

EMERGENCY CARE SERVICES

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

- serious jeopardy to the Subscriber's health (or, with respect to a pregnant individual, the health of the individual or their unborn child);
- serious impairment to bodily function; or
- serious dysfunction of any bodily organ or part; or
- with respect to a pregnant individual 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 individual or the unborn child.

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

Coverage for Emergency Care shall be provided in accordance with the terms and conditions of the appropriate Benefit section of this Certificate (for example: *"Hospital Services"* and *"Surgical/Medical Services"*). If you disagree with the Plan's determination in processing your Benefits as non-Emergency Care instead of Emergency Care, you may call Customer Service at the toll-free number on the back of your Identification Card. Please review the Member Complaints and Appeals section of this Certificate for specific information on your right to seek and obtain a full and fair review of your Claims.

HOSPITAL SERVICES

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

- **Bed and Board**

  Bed, board, and general nursing service in:

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

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

- **Ancillary Services**
  - Operating, delivery and treatment rooms;
  - Prescribed drugs;

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

– **Emergency Accident Care**

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

– **Emergency Medical Care**

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

– **Surgery**

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

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

– **Routine Nursery Care**

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

SURGICAL/MEDICAL SERVICES

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

– **Surgery**

Benefits include visits before and after Surgery.

- If an incidental procedure[1] is carried out at the same time as a more complex primary procedure, then Benefits will be **available** for only the primary procedure. **Separate Benefits will not be available for any incidental procedures performed at the same time.**
- When more than one surgical procedure is performed through more than one route of access during one operation, you are covered for:
    - the primary procedure; plus

[1] *A procedure performed at the same time as the primary surgical procedure, but which is clinically integral to the performance of the primary procedure and is not reimbursed separately.*

- 50% of the amount available for each of the additional procedures had those procedures been performed alone.

- Sterilization, regardless of Medical Necessity.

- **Assistant Surgeon**

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

- **Anesthesia**

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

- **Inpatient Medical Services**

  Medical Care when you are an Inpatient for a condition not related to Surgery, pregnancy or Mental Health and Substance Use Disorder, except as specified.

  - Inpatient Medical Care Visits

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

  - Intensive Medical Care

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

  - Concurrent Care

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

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

  - Consultation

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

  - Newborn Well Baby Care

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

- **Outpatient Medical Services**

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

  - Emergency Accident Care

    Treatment of accidental bodily injuries.

  - Emergency Medical Care

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

  - Home, Office, and Other Outpatient Visits.

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

  - Contraceptive Devices which are:

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

– Audiological Services

Audiological services and hearing aids, limited to:

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

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

– **Biomarker Testing**

Benefits will be provided for Medically Necessary Biomarker Testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a disease or condition.

– **Inherited Gene Mutation Testing**

Benefits will be provided for Medically Necessary clinical genetic testing for an inherited gene mutation for individuals with a personal or family history of cancer and for evidence-based cancer imaging for individuals with an increased risk of cancer, when recommended by your Provider.

Benefits for clinical genetic testing and evidence-based cancer imaging will be provided at no cost-share when obtained from a Participating Provider, after your deductible has been met.

– **Diagnostic and Supplemental Examinations for Breast Cancer**

Benefits will be provided for Medically Necessary and clinically appropriate diagnostic examinations to evaluate abnormalities in the breast that are:

- seen or suspected from a screening examination for breast cancer;
- detected by another means of examination; or
- suspected based on the medical history or family history of the individual.

Benefits will be provided for Medically Necessary and clinically appropriate supplemental examinations of the breast that are:

- used to screen for breast cancer when there is no abnormality seen or suspected; and
- based on personal or family medical history or additional factors that increase the individual's risk of breast cancer, including heterogeneously or extremely dense breasts.

These examinations may include, but are not limited to, a contrast enhanced mammogram, Diagnostic Mammogram, Breast Magnetic Resonance Imaging, Breast Ultrasound, or molecular breast imaging. Benefits for Diagnostic and Supplemental Examinations for Breast Cancer will be provided at no cost-share, after your deductible has been met.

In addition to the ***Definitions*** section of this Certificate, the following definitions are applicable to this provision:

- **Diagnostic Mammogram**

  A diagnostic tool that uses x-ray and is designed to evaluate abnormality in a breast.

- **Breast Magnetic Resonance Imaging**

  A diagnostic tool used to produce detailed pictures of the structure of the breast.

- **Breast Ultrasound**

  A non-invasive, diagnostic imaging technique that uses high-frequency sound waves to produce detailed images of the breast.

- **Standard Fertility Preservation Services**

  Benefits will be provided for Standard Fertility Preservation Services for those who are within reproductive age, when Medically Necessary treatments may directly or indirectly cause Iatrogenic Infertility. Standard Fertility Preservation Services are not subject to Prior Authorization requirements.

SERVICES DELIVERED VIA TELEMEDICINE

This Plan provides Benefits for Covered Services appropriately provided through Telemedicine Visits. 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, or as otherwise allowed by applicable law. Cost-sharing amounts for Covered Services appropriately provided through Telemedicine Visits 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.

OUTPATIENT DIAGNOSTIC SERVICES

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

OUTPATIENT THERAPY SERVICES

- Radiation Therapy
- Chemotherapy

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

- Respiratory Therapy
- Dialysis Treatment

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

- Infusion Therapy

– Physical Therapy, Occupational Therapy, Speech Therapy and Manipulative Therapy.

Benefits for Outpatient Physical Therapy, Outpatient Occupational Therapy, Outpatient Speech Therapy (including visits to the Subscriber's home) and Outpatient Manipulative Therapy are limited to the number of visits specified in the *Schedule of Benefits for Comprehensive Health Care Services* in the front of this Certificate. This visit limit is not applicable to services associated with treatment of Mental Health and Substance Use Disorders.

MEDICAL DRUG BENEFIT PROGRAM

Certain Prescription Drugs administered by a health care professional may be covered under this Benefit section. Coverage is based on recommendations of a committee, which is made up of Physicians and pharmacists from across the country, some of whom are affiliated with BCBSOK. The committee considers existing FDA-approved drugs, as well as newly FDA-approved drugs, using factors including but not limited to, safety, effectiveness, cost, and how they compare with other Covered Prescription Drugs.

Medical Drug Benefit Review and Limitations

The following rules apply to Prescription Drugs which may be covered under this Benefit section:

- Accelerated FDA-approved Drugs: Prescription Drugs which may be administered by a health care professional and have been approved by the FDA through the accelerated approval program are subject to review by the Plan and may not be covered.
- New FDA-approved Drugs: Prescription Drugs which may be administered by a health care professional and have recently received FDA approval are subject to review by the Plan and may not be covered.
- Self-administered formulations: Select medications may be excluded from coverage under this Benefit section when a self-administered formulation of the drug is available.
- Therapeutic equivalents or alternatives: Certain Prescription Drugs administered by a health care professional have therapeutic equivalents or therapeutic alternatives that are used to treat the same condition. Benefits may be limited to only certain therapeutic alternatives. Depending on your Benefit Plan, therapeutic equivalents or therapeutic alternatives may be covered through your Prescription Drug Benefit.

Note: To learn more about Prescription Drugs that may be covered under this Benefit section or about how to request an exception, you, your Provider, or your authorized representative may contact Customer Service at the toll-free number on the back of your Identification Card or visit www.bcbsok.com/find-care/medical-rx.

For Prescription Drugs that are not otherwise covered under this Benefit section, your Provider may request an exception by submitting a completed Medical Drug Benefit Program Coverage Exception Request form available at www.bcbsok.com/docs/provider/ok/education/forms/ok-mbta-exception-request.pdf. Notice of coverage determinations will be provided to you and your Provider.

MATERNITY SERVICES

– *"Hospital Services"* and "*Surgical/Medical Services"* from a Provider for:
  - Normal Pregnancy

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

    Physical effects directly caused by pregnancy, but which are not considered from a medical viewpoint to be the effect of normal pregnancy, including conditions related to ectopic pregnancy or those that require cesarean section.

- Interruptions of Pregnancy
  - Miscarriage.
  - Abortion, when the life of the pregnant individual is endangered.

- Covered Maternity Services include the following:
  - A minimum of 48 hours of Inpatient care at a Hospital, or a birthing center licensed as a Hospital, following a vaginal delivery for the birthing parent 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 birthing parent 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 that is not licensed as a Hospital but that is accredited as a freestanding birthing center by the Commission for the Accreditation of Birth Centers. 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 birthing parent 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 birthing parent'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 birthing parent 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 birthing parent 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 birthing parent and newborn infant;
      - The gestational age, birth weight and clinical condition of the newborn infant;
      - The demonstrated ability of the birthing parent to care for the newborn infant post-discharge; and
      - The availability of post-discharge follow-up to verify the condition of the newborn infant in the first 48 hours after delivery.
    - The Plan covers one home visit, within 48 hours of discharge, by a licensed health care Provider whose scope of practice includes providing postpartum care. Such visits shall include, at a minimum:

- Physical assessment of the birthing parent 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 birthing parent's discretion, visits may occur at the facility of the Provider instead of the home.

MASTECTOMY AND RECONSTRUCTIVE SURGICAL SERVICES

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

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

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

– Coverage for reconstructive breast Surgery performed as a result of a partial or total mastectomy. Covered Services shall consist of the following, when provided in a manner determined in consultation with the attending Physician and the patient:
  – Reconstruction of the breast on which the mastectomy has been performed;
  – Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
  – Prostheses and physical complications at all stages of mastectomy, including lymphedema.

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

HUMAN ORGAN, TISSUE AND BONE MARROW TRANSPLANT SERVICES

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

Prior Authorization must be obtained at the time the Subscriber is referred for a transplant consultation and/or evaluation. It is the Subscriber's responsibility to make sure Prior Authorization is obtained. Failure to obtain Prior Authorization for Inpatient services may result in a $500 Benefit reduction, or denial of Benefits, as set forth in the *"Prior Authorization"* requirements of this Certificate (see *Important Information* section). The Plan has the sole and final authority for approving or declining requests for Prior Authorization.

– **Definitions**

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

  – **Bone Marrow Transplant**

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

    - the harvest of stem cells or progenitor cells, whether from the bone marrow or from the blood, from a third-party donor (allogeneic transplant) or from the patient (autologous transplant);
    - processing and/or storage of the stem cells or progenitor cells after harvesting;
    - the administration of High-Dose Chemotherapy and/or High-Dose Radiation Therapy, when this step

is prescribed by the treating Physician;

- the infusion of the harvested stem cells or progenitor cells; and
- hospitalization, observation, and management of reasonably anticipated complications such as graft versus host disease, infections, bleeding, organ or system toxicities and low blood counts.

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

– **High-Dose Chemotherapy**

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

– **High-Dose Radiation Therapy**

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

– **Prior Authorization**

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

– **Procurement Services**

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

– **Transplant Services**

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

- musculoskeletal transplants;
- parathyroid transplants;
- cornea transplants;
- heart-valve transplants;
- kidney transplants;
- heart transplants;
- single lung, double lung, and heart/lung transplants;

- liver transplants;
- intestinal transplants;
- small bowel/liver or multivisceral (abdominal) transplants;
- pancreas transplants;
- islet cell transplants; and
- bone Marrow Transplants.

- **Exclusions and Limitations Applicable to Organ/Tissue/Bone Marrow Transplants**
  - The transplant must meet the criteria established by the Plan for assessing and performing organ or tissue transplants, or Bone Marrow Transplant procedures, as set forth in the Plan's written medical policies.
  - In addition to the ***Exclusions*** set forth elsewhere in this Certificate, no Benefits will be provided for the following organ or tissue transplants or Bone Marrow Transplants or related services:
    - adrenal to brain transplants.
    - allogeneic islet cell transplants.
    - high-Dose Chemotherapy or High-Dose Radiation Therapy if the associated autologous or allogeneic Bone Marrow Transplant, stem cell or progenitor cell treatment or rescue is not a Covered Service.
    - small bowel transplants using a living donor.
    - any organ or tissue transplant or Bone Marrow Transplant from a non-human donor or for the use of non-human organs for extracorporeal support and/or maintenance.
    - any artificial device for transplantation/implantation, except in limited instances as reflected in the Plan's written medical policies.
    - any organ or tissue transplant or Bone Marrow Transplant procedure which the Plan considers to be Experimental, Investigational and/or Unproven in nature.
    - expenses related to the purchase, evaluation, Procurement Services, or transplant procedure if the organ or tissue or bone marrow or stem cells or progenitor cells are sold rather than donated to the Subscriber recipient.
    - all services, provided directly for or relative to any organ or tissue transplant, or Bone Marrow Transplant procedure which is not specifically listed as a Covered Service in this Certificate.
  - The transplant must be performed in and by a Provider that meets the criteria established by the Plan for assessing and selecting Providers in the performance of organ or tissue transplants or Bone Marrow Transplant procedures.

- **Donor Benefits**

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

  - When both the recipient and the living donor are Subscribers, each is entitled to the Benefits of this Certificate.
  - When only the recipient is a Subscriber, both the donor and the recipient are entitled to the Benefits of this Certificate. The donor Benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage or other Blue Cross or Blue Shield coverage or any government program. Benefits provided to the donor will be applied to the

recipient's coverage under this Certificate.

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

- **Research-Urgent Bone Marrow Transplant Benefits Within National Institutes of Health Clinical Trials Only**

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

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

AMBULATORY SURGICAL FACILITY SERVICES

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

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

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

SERVICES RELATED TO TREATMENT OF AUTISM AND AUTISM SPECTRUM DISORDER

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

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

- Behavioral health counseling and treatment programs, including Applied Behavior Analysis, that are:

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

Applied Behavior Analysis is subject to the "Prior Authorization" requirements set forth in the *Important Information* section of this Certificate. If you fail to comply with these requirements, Benefits for Covered Services may be reduced or denied.

- Medications prescribed by a licensed Physician and any health-related services deemed Medically Necessary to determine the need or effectiveness of the medications.
- Direct or consultative services provided by a psychiatrist or psychologist licensed in the state in which the psychiatrist or psychologist practices.
- Therapeutic care services provided by licensed or certified speech therapists, occupational therapists, or physical therapists. Speech Therapy, Physical Therapy and Occupational Therapy visits related to treatment of Autism Spectrum Disorder are not subject to the limitations specified under "Outpatient Therapy Services".

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

PSYCHIATRIC CARE SERVICES

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

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

– Inpatient Facility Services

Covered Inpatient Services provided by a Hospital, Psychiatric Hospital, Residential Treatment Center, or other Plan-approved Provider .

– Inpatient Medical Services

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

- Medical Care visits, **limited to one visit or other service per day**;
- Individual Psychotherapy;
- Group Psychotherapy;
- 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 Medical Services when provided for the Outpatient treatment of Mental Health and Substance Use Disorder by a Hospital, Psychiatric Hospital, Residential Treatment Center, Physician, or other Plan-approved Provider:

  - Outpatient Medical Care visits;
  - Psychological testing;
  - Neuropsychological testing;
  - Partial Hospitalization Program;
  - Intensive Outpatient Program;
  - Electro-convulsive Therapy (ETC);
  - Transcranial magnetic stimulation (TMS).

NOTE: Covered Services for treatment of Mental Health and Substance Use Disorder include those delivered through behavioral health integration and the psychiatric collaborative care model.

NOTE: You or your Provider may contact Customer Service at the number on the back of your Identification Card or visit our website at www.bcbsok.com for assistance with obtaining Covered Services for treatment of Mental Health and Substance Use Disorders from a Non-Participating Provider at the In-Network Benefit level, if such care is not available from a Participating Provider within:

- 24 hours for emergency care;
- 7 days for residential or hospitalization care; or
- 30 days for all other care.

AMBULANCE SERVICES

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

PRIVATE DUTY NURSING SERVICES

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

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

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

REHABILITATION CARE/HABILITATION CARE

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

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

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

SKILLED NURSING FACILITY SERVICES

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

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

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

No Benefits are available:

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

HOME HEALTH CARE SERVICES

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

- medical and surgical supplies;
- prescribed drugs;
- oxygen and its administration.

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

- professional services of an RN, LPN or LVN;

- medical social service consultations;
- health aide services while you are receiving covered nursing or Therapy Services;
- services of a licensed registered dietitian or licensed certified nutritionist, when authorized by the patient's supervising Physician and when Medically Necessary, including but not limited to, diabetes self-management training.

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

We do not pay Home Health Care Benefits for:

- homemaker services;
- maintenance therapy;
- Speech Therapy;
- Durable Medical Equipment;
- food or home-delivered meals;
- Infusion Therapy, **except when you have received Prior Authorization from the Plan for these services.**
- intravenous drug, fluid, or nutritional therapy, **except when you have received Prior Authorization from the Plan for these services.**

HOSPICE SERVICES

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

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

DENTAL SERVICES FOR ACCIDENTAL INJURY

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

DIABETES EQUIPMENT, SUPPLIES AND SELF-MANAGEMENT SERVICES

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

- Insulin pumps and appurtenances thereto;
- Insulin infusion devices;
- Oral agents for controlling blood sugar;
- Podiatric appliances for prevention of complications associated with diabetes; and
- Other diabetes equipment and related services that are determined Medically Necessary by the Oklahoma State Board of Health, provided such equipment and supplies have been approved by the federal Food and Drug Administration (FDA).

- Diabetes self-management training in an Inpatient or Outpatient setting which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalizations and complications. Diabetes self-management training must be conducted in accordance with the standards developed by the Oklahoma State Board of Health in consultation with a national diabetes association affiliated with this state and at least three medical directors of health benefit Plans selected by the Oklahoma State Department of Health. Coverage for diabetes self-management training, including medical nutrition therapy relating to diet, caloric intake, and diabetes management (excluding programs of which the only purpose are weight reduction) shall be limited to the following:
  - Visits Medically Necessary upon the diagnosis of diabetes;
  - A Physician diagnosis which represents a significant change in the patient's symptoms or condition making Medically Necessary changes in the patient's self-management; and
  - Visits when reeducation or refresher training is Medically Necessary.

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

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

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

SERVICES RELATED TO CLINICAL TRIALS

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

- Any of the following federally funded or approved trials:
  - The Centers for Disease Control and Prevention of the United States Department of Health and Human Services;
  - The National Institutes of Health (NIH);
  - The Centers for Medicare and Medicaid Services;

- The Agency for Healthcare Research and Quality;
- A cooperative group or center of any of the previous entities;
- The United States Food and Drug Administration;
- The United States Department of Defense (DOD);
- The United States Department of Veterans Affairs (VA);
- A qualified non-governmental research entity identified in guidelines issued by the NIH for center support grants or the DOD, VA, or Department of Energy if the study has been reviewed and approved through a peer review system; or
- An institutional review board of an institution in this state that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services.

– A clinical trial conducted under an FDA Investigational new drug application.

– A drug trial that is exempt from the requirement of an FDA Investigational new drug application.

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

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

– The Investigational item, device, or service, itself;

– Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or

– A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

DURABLE MEDICAL EQUIPMENT

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

– It is used in the Subscriber's home, place of residence or dwelling;

– It provides therapeutic benefits or enables the Subscriber to perform certain tasks that he or she would be unable to perform otherwise due to certain medical conditions and/or illness;

– It can withstand repeated use and is primarily and customarily used to serve a medical purpose;

– It is generally not useful to a person in the absence of an illness or injury; and

– It is prescribed by a Physician and meets the Plan's criteria of Medical Necessity for the given diagnosis.

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

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

Jacuzzi pumps, humidifiers or modifications to the Subscriber's home or vehicle.

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

NOTE: For Durable Medical Equipment and supplies obtained from an Out-of-Network Provider, either because your Provider deemed it necessary that you receive it within twenty-four (24) hours, or because there wasn't a Network Provider within fifteen (15) miles of your home address, the cost-sharing requirements will be the same as if they were obtained in-network.

PROSTHETIC APPLIANCES

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

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

ORTHOTIC DEVICES

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

Benefits will be provided for the following orthotic devices:

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

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

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

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

WIGS OR OTHER SCALP PROSTHESES

Wigs or other scalp prostheses which are necessary for the comfort and dignity of the Subscriber, and which are required due to any medically induced hair loss.

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

ROUTINE FOOT CARE

Benefits for Medically Necessary routine foot care, when obtained from a licensed Provider.

Outpatient Prescription Drugs and Related Services

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

COVERED SERVICES

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

- Prescription Drugs dispensed for a Subscriber's Outpatient use, when recommended by and while under the care of a Physician or other Provider.
- Injectable insulin and insulin products, but only when dispensed in accordance with a written prescription by a licensed Physician or other Provider even though a prescription may not be required by law.
- Oral contraceptives, when prescribed by a licensed Physician or other Provider.
- Prescription Drugs prescribed for treatment of attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD).
- Oral Chemotherapy when prescribed by a licensed Physician after your Deductible has been met. Your Copayment or Coinsurance amount will not apply to orally administered anticancer medications when received from a Participating Pharmacy. Coverage of prescribed orally administered anticancer medications when received from a Non-Preferred Specialty Pharmacy Provider or non-Participating Pharmacy Provider will be provided on a basis no less favorable than intravenously administered or injected cancer medications.
- Self-injectable and other self-administered Prescription Drugs (including Chemotherapy), when dispensed by a Pharmacy. Self-injectable and other self-administered drugs purchased from a Physician and administered in their office are not covered. Many self-injectable/self-administered drugs are classified as "Specialty Pharmacy Drugs" and should be purchased from a Participating Specialty Pharmacy.
- Specialty Pharmacy Drugs (should be purchased from a Participating Specialty Pharmacy in order to receive the highest level of Benefits).
- Select vaccinations (when administered by a Participating Retail Pharmacy Vaccination Network Provider). For a current listing of vaccines available through this coverage, call Customer Service at the number listed on your Identification Card or visit the Plan's website at https://www.bcbsok.com/prescription-drugs/managing-prescriptions/drug-lists. NOTE: Select vaccinations administered through a Participating Retail Pharmacy Vaccination Network Provider are not subject to the Deductible, Copayment and/or Coinsurance provisions of this Certificate.
- Drugs prescribed by a Physician or other Provider as part of *"Preventive Care Services"* as defined in this Certificate.

NOTE: Prescription Drugs that are approved by the FDA through the accelerated approval program may be considered Experimental/Investigational/Unproven and may not be covered.

In order to be a Covered Drug under this ***Outpatient Prescription Drugs and Related Services*** section, the Prescription Drugs must be shown on the Drug List. The drugs on the Drug List have been selected to provide coverage for a broad range of diseases. Each drug appearing on the list shows to which tiered category it belongs. For example, most Generic Drugs are categorized as Tier 1 or Tier 2 drugs, while Specialty Drugs may

be classified as Tier 5 or Tier 6 drugs (depending upon the benefit Plan in which you are enrolled). You may refer to the ***Schedule of Benefits for Outpatient Prescription Drugs and Related Services*** to determine the level of coverage available for each drug tier/category.

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

Drugs listed on the Drug List are selected by the Plan based upon the recommendations of a committee, which is made up of current and previously practicing Physicians and pharmacists from across the country, some of whom are employed by or affiliated with the Plan. The committee considers existing drugs approved by the FDA, as well as those newly FDA-approved for inclusion on the Drug List. Entire drug classes are also regularly reviewed. Some of the factors committee members evaluate include each drug's safety, effectiveness, cost and how it compares with drugs currently on the Drug List. Positive changes (e.g., adding drugs to the Drug List, drugs moving to a lower payment tier) occur quarterly after review by the committee. Changes to the Drug List that could have an adverse financial impact to you (e.g., drug exclusion, drug moving to a higher payment tier, or drugs requiring step therapy or Prior Authorization) occur quarterly or annually. However, when there has been a pharmaceutical manufacturer's recall or other safety concern, changes to the Drug List may occur more frequently.

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

RETAIL PHARMACY PROGRAM

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

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

EXTENDED PRESCRIPTION DRUG SUPPLY PROGRAM

Your coverage includes Benefits for up to a 90-day supply of Maintenance Prescription Drugs purchased from a Participating Pharmacy which may only include Preferred Participating retail or Participating Mail-Order Pharmacies. Benefit amounts are listed in the ***Schedule of Benefits for Outpatient Prescription Drugs and Related Services.*** Your cost will be the appropriate Deductible, Copayment and/or Coinsurance amount indicated in the ***Schedule of Benefits for Outpatient Prescription Drugs and Related Services.***

Benefits will not be provided for more than a 30-day supply of drugs obtained from a Prescription Drug Provider *not* participating in the Extended Prescription Drug Supply Program.

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

MAIL-ORDER PHARMACY PROGRAM

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

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

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

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

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

SPECIALTY PHARMACY DRUG PROGRAM

This program provides delivery of medications directly to your health care Provider for administration or to the home of the patient that is undergoing treatment for a complex medical condition. To receive the highest level of Benefits, Specialty Drugs **should be obtained through an in-network Specialty Pharmacy.**

Coverage for Specialty Drugs are limited to a 30-day supply. However, some Specialty Drugs have FDA approved dosing regimens exceeding the 30-day supply limits and may be allowed greater than a 30-day supply. Cost share will be based on day supply (1–30-day supply, 31–60-day supply, 61–90-day supply) dispensed.

To determine which drugs are Specialty Drugs, you should refer to the Plan's website at https://www.bcbsok.com/ok/documents/rx-drugs/specialty-drug-list-ok.pdf or by contacting Customer Service at the toll-free number on your Identification Card. Your cost will be the appropriate Deductible, Copayment and/or Coinsurance amount indicated in the ***Schedule of Benefits for Outpatient Prescription Drugs and Related Services.***

MEDSYOURWAY™

MedsYourWay™ ("MedsYourWay") may lower your Out-of-Pocket costs for select Covered Drugs purchased at select Retail Participating Pharmacies. MedsYourWay is a program that automatically compares available Drug discount card prices and prices under your Benefit Plan for select Covered Drugs and establishes your Out-of-Pocket cost to the lower price available. At the time you submit or pick up your prescription, present your Identification Card to the pharmacist. This will identify you as a participant in MedsYourWay and allow you the lower price available for select Covered Drugs.

The amount you pay for your prescription will be applied, if applicable, to your Deductible and Out-of-Pocket Limit Available select Covered Drugs and Drug discount card pricing through MedsYourWay may change occasionally. Certain restrictions may apply, and certain Covered Drugs or Drug discount cards may not be available for the MedsYourWay program. You may experience a different Out-of-Pocket amount for select Covered Drugs depending upon which Retail Pharmacy is utilized. For additional information regarding MedsYourWay, please contact a customer service representative at the toll-free number on the back of your Identification Card or access the Plan's website www.bcbsok.com. Participation in MedsYourWay is not mandatory and you may choose not to participate in the program at any time by contacting your customer service representative at the toll-free number on

the back of your Identification Card or access the Plan's website www.bcbsok.com. In the event MedsYourWay fails to provide, or continue to provide, the program as stated, there will be no impact to you. In such an event, you will pay the amount indicated in the ***Schedule of Benefits for Outpatient Prescription Drugs and Related Services.*** MedsYourWay may not be available in all states or pharmacies and will be operated only to the extent permitted by law.

PAYMENT OF BENEFITS

Benefits are provided for Prescription Drugs dispensed for a Subscriber's Outpatient use when recommended by and while under the care of a Physician or other Provider, provided such care and treatment is Medically Necessary.

- Benefits for Prescription Drugs are available to the Subscriber only:
  - in accordance with a Prescription Order; and
  - after the Subscriber has met the Deductible, if applicable; and
  - after the Subscriber has incurred charges equal to the Copayment and/or Coinsurance applicable to each Prescription Order**. If the charge for your prescription is *less* than your Copayment and/or Coinsurance, you will pay the lesser amount.**
- When Prescription Drugs and related services are dispensed by a Participating Pharmacy, the Plan will pay directly to the Pharmacy the Allowable Charge for the drugs, less the applicable Deductible, Copayment and/or Coinsurance amount specified in the ***Schedule of Benefits for Outpatient Prescription Drugs and Related Services.***
- If your Prescription Order is filled by an Out-of-Network Pharmacy, you will need to pay the full cost of the drugs directly to the Pharmacy and then submit a claim to the Plan in order to receive any Benefits under this program. In addition to any Deductible, Copayment and/or Coinsurance amounts applicable to your coverage, you will be responsible for the cost difference, if any, between the Pharmacy's billed charges and the Allowable Charge determined by the Plan. **NOTE: Vaccinations administered by a Pharmacy that is not a Participating Retail Pharmacy Vaccination Network Provider are not covered under this *Outpatient Prescription Drugs and Related Services* section.**
- You may not be required to pay the difference in cost between the Allowable Charge of the Brand Name Drug and the Allowable Charge of the Generic Drug if there is a medical reason (e.g., adverse event) you need to take the Brand Name Drug and certain criteria are met. Your health care Provider can submit a request to waive the difference in cost between the Allowable Charge of the Brand Name Drug and Allowable Charge of the Generic Drug. In order for this request to be reviewed, your health care Provider must send in a Med Watch form to the Food and Drug Administration (FDA) to let them know the issues you experienced with the Generic equivalent. Your health care Provider must provide a copy of this form when requesting the waiver. The FDA MedWatch form is used to document adverse events, therapeutic inequivalence/failure product quality problems, and product use/medication error. This form is available on the FDA website. If the waiver is granted, applicable Copayment, Coinsurance, and any Deductible will still apply. For additional information, you may access the website at www.bcbsok.com or contact customer service at the toll-free number on your Identification Card.

PRESCRIPTION DRUG SUPPLY/DISPENSING LIMITS

The Plan has the right to determine the day supply or unit dosage limits at its sole discretion. Benefits may be denied if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the stated maximum supply limitations. Some drugs covered under your Plan may be subject to certain supply/fill limitations pursuant to diagnoses or new-to-therapy requirements, Plan design, and/or state or

federal regulations. For specific drug supply/fill information, please call the customer service number located on your Identification Card.

Benefit Supply Limits per Prescription

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

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

- **Retail Pharmacy and Specialty Pharmacy Network Providers** – During each one-month period, up to a 30-day supply for drugs. However, some Specialty Drugs have FDA approved dosing regimens exceeding the 30-day supply limits and may be allowed greater than a 30-day supply. Cost share will be based on day supply (1–30-day supply, 31–60-day supply, 61–90-day supply) dispensed.
- **Extended Prescription Drug Supply Program and Mail-Order Pharmacy Program –** During each three-month period, up to a 90-day supply for drugs designated by the Plan as Maintenance Prescription Drugs. If less than a 90-day supply is ordered, the extended supply or mail-order Copayment and/or Coinsurance will still apply.

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

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

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

You are entitled to synchronize your Prescription Order refills for one or more chronic conditions. Synchronization means the coordination of medication refills for two or more medications that you may be taking for one or more chronic conditions such that medications are refilled on the same schedule for a given period of time. When necessary to permit synchronization, the Plan shall apply a prorated daily cost-sharing rate to any covered medication dispensed by a Participating Pharmacy. Some prescriptions may be subject to a shorter refill window. Please call Customer Service for details.

Refills for covered eye drop Prescription Orders are available after 70% has been used.

Prescription contraceptive drugs are available for up to a six-month supply.

- **Multi-Category Split-Fill Program**

If this is your first time using select medications in certain drug classes (e.g., medications for cancer, multiple sclerosis, lung disorders, etc.) or if you have not filled one of these medications within 120 days, you may only be able to receive a partial fill (14 – 15-day supply) of the medication for up to the first 3 months of therapy. This is to help see how the medication is working for you. If you receive partial fill, your Copayment and/or Coinsurance after your Deductible will be adjusted to align with the quantity of medication dispensed. If the medication is working for you and your Physician wants you to continue on this medication, you may be eligible to receive up to a 30-day supply after completing up to 3 months of the partial supply. For a list of drugs that are included in this program, please visit the https://www.bcbsok.com/prescription-drugs/pharmacies/programs website.

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

In addition to the supply limits stated above and regardless of the quantity of a Covered Drug prescribed by a

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

– **Controlled Substances Limitation**

  If the Plan determines that a Subscriber may be receiving quantities of controlled substance medications not supported by FDA approved dosages or recognized safety or treatment guidelines, Benefits may be subject to a review to determine Medical Necessity, or appropriateness and other restrictions such as limiting coverage to services provided by a certain Provider and/or Pharmacy for the prescribing and dispensing of the controlled substance medication and/or limiting coverage to certain quantities. For the purposes of this provision, controlled substance medications are medications classified and restricted by state or federal laws.

THERAPEUTIC EQUIVALENT RESTRICTIONS

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

EXCLUSIONS AND LIMITATIONS

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

– Drugs/products which are not included on the Drug List, unless specifically covered elsewhere in this Certificate and/or such coverage is required in accordance with applicable law or regulatory guidance.

– Drugs that are not Medically Necessary or treatment recommendations that are not supported by evidence-based guidelines or clinical practice guidelines.

– Non-FDA approved drugs.

– Drugs which by law do not require a Prescription Order from an authorized Provider (except insulin, insulin analogs, insulin pens and prescriptive and nonprescriptive oral agents for controlling blood sugar level); and drugs, insulin, or covered devices for which no valid Prescription Order is obtained.

– Over-the-counter drugs and medications, except those prescribed by a Physician or other Provider as part of the *"Preventive Care Services"* as defined in this Certificate.

– Devices, technologies, and/or Durable Medical Equipment of any type (even though such devices may require a Prescription Order), such as, but not limited to, therapeutic devices, artificial appliances, digital health technologies and/or applications, or similar devices (except disposable hypodermic needles and syringes for self-administered injections).

– Pharmaceutical aids such as excipients found in the USP-NF (United States Pharmacopeia-National Formulary) including, but not limited to, preservatives, solvents, ointment bases, and flavoring, coloring, diluting, emulsifying, and suspending agents.

– Administration or injection of any drugs (except for select vaccines administered by a Participating Pharmacy).

- Vitamins (except those vitamins which by law require a Prescription Order and for which there is no non-prescription alternative).
- Drugs dispensed in a Physician's office or during confinement while a patient in a Hospital, or other acute care institution or facility, including take-home drugs; and drugs dispensed by a nursing home or custodial or chronic care institution or facility.
- Covered Drugs, devices, or other Pharmacy services or supplies for which Benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, including but not limited to, any services or supplies for which Benefits are payable under Part A and Part B of Title XVIII of the Social Security Act (Medicare), or the laws, regulations or established procedures of any county or municipality, except any program which is a state Plan for medical assistance (Medicaid), or any Prescription Drug which may be properly obtained without charge under local, state, or federal programs, unless such exclusion is expressly prohibited by law; provided, however, that this exclusion shall not be applicable to any coverage held by you for Prescription Drug expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.
- Any services provided or items furnished for which the Pharmacy normally does not charge.
- Covered Drugs for which the Pharmacy's usual and customary charge to the general public is less than or equal to the Copayment and/or Coinsurance amount provided under this Certificate.
- Infertility and fertility medication, except for medications for Standard Fertility Preservation Services related to Iatrogenic Infertility.
- Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations except those prescribed by a Physician or other Provider as part of the *"Preventive Care Services"* as defined in this Certificate.
- Drugs required by law to be labeled: "Caution — Limited by Federal Law to Investigational Use", or Experimental, Investigational and/or Unproven drugs, even though a claim is made for the drugs.
- Covered Drugs dispensed in quantities in excess of the amounts stipulated in this ***Outpatient Prescription Drugs and Related Services*** section; or refills of any prescriptions in excess of the number of refills specified by the Physician or by law; or any drugs or medicines dispensed more than one year following the Prescription Order date.
- Fluids, solutions, nutrients, medications (including all additives and Chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous, intramuscular (in the muscle), intrathecal (in the spine), or intraarticular (in the joint) injection in the home setting, except as specifically provided in this Certificate. NOTE: This exception does not apply to dietary formula necessary for the treatment of phenylketonuria (PKU) or other heritable diseases.
- Drugs prescribed and dispensed for the treatment of obesity or for use in any program of weight reduction, weight loss or dietary control.
- Drugs the use or intended use of which would be illegal, unethical, imprudent, abusive, not Medically Necessary, or otherwise improper.
- Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the Identification Card.
- Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction, which is not covered under this Certificate, or for which Benefits have been exhausted.
- Rogaine, Minoxidil or any other drugs, medications, solutions, or preparations used or intended for use in the

treatment of hair loss, hair thinning or any related condition, whether to facilitate or promote hair growth, to replace lost hair or otherwise.

- Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.
- Prescription Orders for which there is an over-the-counter product available with the same active ingredient(s), in the same strength, unless otherwise determined by the Plan.
- Athletic performance enhancement drugs.
- Drugs to treat sexual dysfunction or erectile dysfunction, including, but not limited to, sildenafil citrate (Viagra), phentolamine (Regitine), alprostadil (Prostin, Edex, Caverject), and apomorphine.
- Compounded medications. For purposes of this exclusion, "compounded medications" are customized medications made by mixing, assembling, packaging or labeling drugs that are not commercially available in a specific dosage form, strength, or formulation.
- Replacement of drugs or other items that have been lost, stolen, destroyed or misplaced.
- Shipping, handling or delivery charges.
- Certain drug classes where there are over-the counter alternatives available.
- Institutional packs and drugs which are repackaged by anyone other than the original manufacturer.
- Bulk powders.
- Diagnostic agents, except for diabetic testing supplies or test strips.
- Any self-injectable and other self-administered drugs purchased from a Physician and administered in their office.
- Drugs determined by the Plan to have inferior efficacy or significant safety issues.
- New-to-market FDA-approved drugs which are subject to review by Prime Therapeutics Pharmacy and Therapeutic (P&T) Committee prior to coverage of the drug.
- Cannabis. Cannabis means all parts of the plant genus Cannabis containing delta-9-tetrahydrocannabinol (THC) as an active ingredient, whether growing or not, the seeds of the plant, the resin extracted from any part of the plant, and every cannabis-derived compound, manufacture, salt, derivative, mixture or preparation of the plant, its seeds or its resin. Cannabis with THC as an active ingredient may be called marijuana.

PRESCRIPTION DRUG PRIOR AUTHORIZATION AND STEP THERAPY PROCESS

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

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

You can obtain a listing of the drugs which require Prior Authorization or Step Therapy by contacting a Customer

Service Representative at the number shown on your Identification Card. Or you may request a listing by writing to:

Blue Cross and Blue Shield of Oklahoma
PO Box 655924
Dallas, TX 75265-5924

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

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

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

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

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

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

Prime Therapeutics
PO Box 25136
Lehigh Valley, PA 18002-5136

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

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

STEP THERAPY EXCEPTION REQUESTS

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

you will receive with the denial determination. Call the number on the back of your Identification Card if you have any questions.

EXCEPTION REQUESTS

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

Exclusions

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

WHAT IS NOT COVERED

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

- Which are not prescribed by or performed by or upon the direction of a Physician or other Provider.
- Which the Plan determines are not Medically Necessary, except as specified.
- For any services related to a non-Covered Service. Related services are:
  - services in preparation for the non-Covered Service;
  - services in connection with providing the non-Covered Service;
  - hospitalization required to perform the non-Covered Service; or
  - services that are usually provided following the non-Covered Service, such as follow-up care or therapy after Surgery.
- Received from other than a Provider.
- Which are in excess of the Allowable Charge, as determined by the Plan.
- Which the Plan determines are Experimental, Investigational and/or Unproven in nature. You may contact Customer Service at the toll-free number on the back of your Identification Card for more information about what Experimental/Investigational and/or Unproven services or supplies may be excluded.
- Clinical technology, services, procedures, and service paradigms designated by a temporary (CPT® Category III) code are not covered, except for certain services otherwise specified by state or federal law, or federal coverage or billing guidelines.
- For any illness or injury occurring in the course of employment if whole or partial compensation or Benefits are or might have been available under the laws of any governmental unit; any policy of workers' compensation insurance; an employer's insured and/or self-funded workers' compensation plan or any other plan providing coverage for work-related illness or injury; or according to any recognized legal remedy arising from an Employer-Employee relationship. This applies whether or not you claim the Benefits or compensation or recover the losses from a third party.
  - You agree to:
    - pursue your rights under the workers' compensation laws;
    - take no action prejudicing the rights and interests of the Plan; and
    - cooperate and furnish information and assistance the Plan requires to help enforce its rights.
  - If you receive any money in settlement of your Employer's liability, regardless of whether the settlement includes a provision for payment of your medical bills, you agree to:
    - hold the money in trust for the benefit of the Plan to the extent that the Plan has paid any Benefits or would be obligated to pay any Benefits; and

    - repay the Plan any money recovered from your Employer or insurance carrier.

- To the extent payment has been made under Medicare or to the extent governmental units provide Benefits or would have provided benefits if you had applied for and claimed those Benefits (some state or federal laws may affect how we apply this exclusion).
- For any illness or injury suffered after the Subscriber's Effective Date as a result of war or any act of war, declared or undeclared, when serving in the military or any auxiliary unit thereto.
- For which you have no legal obligation to pay in the absence of this or like coverage.
- Received from a dental or medical department maintained by or on behalf of an Employer, mutual benefit association, labor union, trust, or similar person or Group.
- Any services, supplies or drugs provided to a Subscriber outside the United States, except for Emergency Care.
- For cosmetic Surgery or complications resulting therefrom, including Surgery to improve or restore your appearance, unless:
  - needed to repair conditions resulting from an accidental injury; or
  - for the improvement of the physiological functioning of a malformed body member resulting from a congenital defect.

  In no event shall this exclusion be applied to deny coverage on the basis that a service or treatment is a complication that arises and/or requires treatment more than one year following the excluded/non-covered cosmetic Surgery.

  In no event will any care and services for breast reconstruction or implantation or removal of breast prostheses be a Covered Service unless such care and services are performed solely and directly as a result of mastectomy which is Medically Necessary.
- Received from a member of your immediate family.
- Received before your Effective Date.
- Received after your coverage stops.
- For any Inpatient care and services, including Rehabilitation Care or Habilitation Care, unless documentation can be provided that, due to the nature of the services rendered or your condition, you cannot receive safe or adequate care as an Outpatient.
- For personal hygiene and convenience items regardless of whether or not recommended by a Physician or other Provider. Examples include computers; air conditioners, air purifiers or filters; humidifiers; or physical fitness equipment, including exercise bicycles or treadmills; or modifications to your home or vehicle.
- For missed appointments or completion of a claim form.
- For Custodial Care such as sitters' or homemakers' services, or care in a place that serves you primarily as a residence when you do not require skilled nursing.
- For foot care only to improve comfort or appearance such as care for flat feet, subluxation, corns, bunions (except capsular and bone Surgery), calluses, toenails, and the like.
- For routine, screening or periodic physical examinations which are not included as *"Preventive Care Services",* as specified in the ***Comprehensive Health Care Services*** section of this Certificate.
- For Testing of:

- blood for measurement of levels of: Lipoprotein a; small dense low-density lipoprotein; lipoprotein subclass high resolution; lipoprotein subclass particle numbers; lipoprotein associated phospholipase A2, which are fat/protein substances in the blood;
- urine for measurement of collagen cross links;
- cervicovaginal fluid for amniotic fluid proteins;
- allergen specific IgG measurement.

- For reverse sterilization.
- For female contraceptive devices when not prescribed by a licensed Provider, including over-the-counter contraceptive products.
- For or related to the planned delivery of a newborn child at home, or in any setting other than a Hospital, accredited freestanding birthing center, or other facility licensed to provide such services.
- For Orthognathic Surgery, osteotomy or any other form of oral Surgery, dentistry or dental processes to the teeth and surrounding tissue (including complications resulting therefrom), except for:
  - the treatment of accidental injury to the jaw, sound natural teeth, mouth or face;
  - the improvement of the physiological functioning of a malformed body member resulting from a congenital defect;
  - dental extractions performed in preparation for radiation treatment for neoplasms involving the jaw/mouth; or
  - dental extractions of diseased teeth prior to a solid organ transplant.
  - Benefits are not provided for dental implants, grafting of alveolar ridges or for any complications arising from such procedures.

  In no event shall this exclusion be applied to deny coverage on the basis that a service or treatment is a complication that arises and/or requires treatment more than one year following the excluded/non-covered cosmetic surgery.
- For or related to Inpatient treatment of any non-covered dental procedure, except that coverage shall be provided for Hospital Services, Ambulatory Surgical Facility Services, and anesthesia services associated with any Medically Necessary dental procedure when provided to a Subscriber who is severely disabled; or who has a medical or emotional condition which requires hospitalization or general anesthesia for dental care; or who, in the judgment of the treating practitioner, is not of sufficient emotional development to undergo a Medically Necessary dental procedure without the use of anesthesia.
- For eyeglasses, contact lenses or examinations for prescribing or fitting them, except for:
  - aphakic patients (including lenses required after cataract Surgery) and soft lenses or sclera shells to treat disease or injury;
  - vision examinations performed in connection with the diagnosis or treatment of disease or injury; or
  - services provided for under *"Preventive Care Services"* in the ***Comprehensive Health Care Services*** section of this Certificate or as specified in the ***Pediatric Vision Care Addendum*** attached to this Certificate.
- For scanning the visible front portion of the eye with computerized ophthalmic diagnostic imaging or measuring the firmness of the front of the eye with corneal hysteresis by air impulse stimulation.

- For eye Surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).
- For hearing aids, tinnitus maskers or examinations for prescribing or fitting them, except as specified under "Audiological Services". Hearing examinations not related to the prescription or fitting of hearing aids will be a Covered Service only when performed in connection with the diagnosis or treatment of disease or injury, or as specified under *"Preventive Care Services"*.
- For diagnosis, treatment or medications for infertility and fertilization procedures, except Standard Fertility Preservation Services to treat Iatrogenic Infertility. Examples include any form of artificial insemination; ovulation induction procedures; in vitro fertilization; embryo transfer; or any other procedures, supplies or medications which in any way are intended to augment or enhance your reproductive ability.
- For treatment of sexual dysfunction not caused by organic disease.
- For treatment, services or supplies of obesity including, but not limited to: weight reduction or dietary control programs, Prescription or non-Prescription Drugs or medications (whether to be taken orally or by injection), appetite suppressants, or nutritional supplements.
- For smoking cessation programs (not including counseling or medications as specified under *"Preventive Care Services"*).
- For medication, drugs, or hormones to stimulate growth.
- For or related to acupuncture, whether for medical or anesthesia purposes, dry needling, or trigger-point acupuncture.
- For unspecified developmental disorders that are not related to a specified medical condition, except as described in the ***Comprehensive Health Care Services*** section under *"Services Related to Treatment of Autism Spectrum Disorder"*.
- For or related to Applied Behavior Analysis, except for the treatment of Autism Spectrum Disorder as described in the ***Comprehensive Health Care Services*** section under "Services Related to Treatment of Autism Spectrum Disorder".
- For hippotherapy, equine assisted learning or other therapeutic riding programs.
- For which the Provider of service customarily makes no direct charge to a Subscriber.
- For treatment of temporomandibular joint dysfunction, including but not limited to diagnostic procedures, splints, orthodontic/orthopedic appliances, restorations necessary to increase vertical dimension or to restore or maintain functional or centric occlusion, alteration of teeth or jaws, Physical Therapy and medication and behavioral modification related to conditions of temporomandibular joint syndrome or any other conditions involving the jaw joint, adjacent muscles or nerves, regardless of cause or diagnosis.
- For or related to transplantation of donor organs, tissues, or bone marrow, except as specified under *"Human Organ, Tissue and Bone Marrow Transplant Services"*.
- For Physician standby services.
- For Continuous Passive Motion (CPM) devices used in treatment of the shoulder or other joints, except for up to 21 days postoperatively for the following surgical procedures: total knee arthroplasty, anterior cruciate ligament reconstruction or open reduction and internal fixation of tibial plateau for distal femur fractures involving the knee joint.
- For services or supplies for:

  - intersegmental traction;
  - all types of home traction devices and equipment;
  - vertebral axial decompression sessions;
  - surface EMG's; which is measurement of muscle electrical activity with electrodes placed on the skin over them;
  - spinal manipulation under anesthesia;
  - muscle testing through computerized kinesiology machines;
  - balance testing through computerized dynamic posturopraphy sensory organization test.
- For treatment of decreased blood flow to the legs with pneumatic compression device high pressure rapid inflation deflation cycle, or treatment of tissue damage in any location with platelet rich plasma.
- For treatment of tissue damage or disease in any location with platelet rich plasma.
- For ductal lavage of the mammary ducts.
- For human donor milk.
- For extracorporeal shock wave treatment, also known as orthotripsy, using either a high-or low-dose protocol, for treatment of plantar fasciitis and all other musculoskeletal conditions.
- For orthoptic training.
- For thermal capsulorrhaphy as a treatment of joint instability, including, but not limited to, instability of shoulders, knees, and elbows.
- For elective abortion, unless the life of the pregnant individual is endangered.
- For transcutaneous electrical nerve stimulator (TENS).
- For Inpatient Substance Use treatment that is not rendered in a Hospital, Psychiatric Hospital, Residential Treatment Center, or other appropriately licensed facility.
- For massage therapy, including, but not limited to, effleurage, petrissage and/or tapotement.
- For transportation services, except as described under *"Ambulance Services"* in the ***Comprehensive Health Care Services*** section of this Certificate.
- For any self-injectable and other self-administered drugs purchased from a Physician and administered in their office.
- Certain Prescription Drugs administered by a health care professional may not be covered under the medical Benefit, including those newly approved by the FDA, those approved through the FDA's accelerated approval program, or if there is a self-administered formulation of the drug available. For additional information, see the "*Medical Drug Benefit Program*" provision.
- For Cannabis. Cannabis means all parts of the plant genus Cannabis containing delta-9-tetrahydrocannabinol (THC) as an active ingredient, whether growing or not, the seeds of the plant, the resin extracted from any part of the plant, and every cannabis-derived compound, manufacture, salt, derivative, mixture or preparation of the plant, its seeds or its resin. Cannabis with THC as an active ingredient may be called marijuana.
- For Viscosupplementation (intra-articular hyaluronic acid injection), except for individuals currently receiving maintenance therapy.

– Which are not specifically named as Covered Services subject to any other specific exclusions and limitations in this Certificate.

We may, without waiving these ***Exclusions***, elect to provide Benefits for care and services while awaiting the decision of whether or not the care and services fall within the ***Exclusions*** listed above. If it is later determined that the care and services are excluded from your coverage, we will be entitled to recover the amount we have allowed for Benefits under this Certificate (see "*Plan's Right of Recoupment*" in the ***General Provisions*** section). You must provide to us all documents needed to enforce our rights under this provision.

General Provisions

This section tells Benefits to which you are entitled;

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

BENEFITS TO WHICH YOU ARE ENTITLED

We provide only the Benefits specified in this Certificate.

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

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

PRIOR APPROVAL

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

NOTICE AND PROPERLY FILED CLAIM

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

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

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

LIMITATION OF ACTIONS

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

PAYMENT OF BENEFITS

You authorize us to make payments directly to Providers giving Covered Services for which we provide Benefits under 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, except as permitted by applicable law.

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

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

However, if you receive Covered Services from an Out-of-Network Provider, you may be responsible for amounts which exceed the Allowable Charge, in addition to any Deductible, Copayment and/or Coinsurance amounts which may apply.

FEDERAL BALANCE BILLING AND OTHER PROTECTIONS

This section is based upon the No Surprises Act, a federal law enacted in 2020 and effective for Plan years beginning on or after January 1, 2022. Unless otherwise required by federal or Oklahoma law, if there is a conflict between the terms of this **FEDERAL BALANCE BILLING AND OTHER PROTECTIONS** section and the terms in the rest of this Certificate, the terms of this section will apply. However, definitions set forth in the ***Federal No Surprises Act Definitions*** provision of this section are for purposes of this section only.

- **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:

  - you are undergoing a course of treatment for a serious and complex condition;
  - you are undergoing institutional or Inpatient care;
  - you are scheduled to undergo nonelective Surgery from the Provider (including receipt of postoperative care from such Provider with respect to such Surgery);
  - you are pregnant or undergoing a course of treatment for your pregnancy, or
  - you are determined to be terminally ill.

  A serious and complex condition is one that (1) for an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm (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 ***Complaint/Appeal Procedure*** section of this Certificate.

- **Federal No Surprises Act Definitions**

  The definitions below apply only to this **FEDERAL BALANCE BILLING AND OTHER PROTECTIONS** section. To the extent thesame terms are defined in both the ***Definitions*** section of this Certificate, those terms will apply only to their use in the Certificate or this **FEDERAL BALANCE BILLING AND OTHER PROTECTIONS** section, respectively.

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

"Emergency Medical Condition" means, for purposes of this section only, a medical condition manifestingitself 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 individual and their 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 section 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 or Non-Participating Emergency Facility during the same visit after your Emergency Medical Condition has stabilized, or as part of outpatient observation or an inpatient or outpatient stay with respect to the same visit, unless:
  - your Non-Participating Provider or Non-Participating Emergency Facility determines you can travel by non-medical or non-emergencytransport;
  - your Non-Participating Provider has provided you with a notice to consent form for balance billing of services; and
  - you have provided informed consent.

"Non-Participating Provider" means, for purposes of this section 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.

"Non-Participating Emergency Facility" means, for purposes of this section only, with respect to a covereditem 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.

"Participating Provider" means, for purposes of this section 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 of 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 section 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, regardless of 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 section only, a median of Contracted rates calculated pursuant to federal or state law, regulation and/or guidance.

"Recognized Amount" means, for purposes of this section 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.

- **Federal No Surprises Act Surprise Billing Protections**

  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.

    - **Claim Payments**

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

    - **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.

- **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.

OUT-OF-AREA SERVICES

Overview

Blue Cross and Blue Shield of Oklahoma ("BCBSOK"), a division of Health Care Service Corporation, has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs". These Inter-Plan Programs operate under rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside the geographic area BCBSOK serves, the claim for those services may be processed through one of these Inter-Plan Programs. The Inter-Plan Programs are described generally below.

When you receive care outside the geographic area BCBSOK serves, you generally obtain care from healthcare providers that have a contractual agreement ("participating 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 healthcare providers in the Host Blue geographic area that do not have a contractual agreement ("nonparticipating providers") with the Host Blue. BCBSOK explains how BCBSOK pays both kinds of providers below.

Inter-Plan Programs Eligibility – Claim Types

All claim types are eligible to be processed through Inter-Plan Programs, as described above, except for all dental care benefits, except when paid as medical claims/benefits, and those prescription drug benefits or vision care benefits that may be administered by a third party contracted by BCBSOK to provide the specific service or services.

BlueCard® Program

Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, BCBSOK will remain responsible for doing what BCBSOK agreed to in the contract. However, the Host Blue is responsible for handling all interactions with its providers, including contracting with participating providers.

When you receive covered healthcare services outside BCBSOK's service area and the claim is processed through the BlueCard® Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed charges for your covered healthcare services; or
- The negotiated price that the Host Blue makes available to BCBSOK.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your provider. Sometimes, it is an estimated price that considers special arrangements with your healthcare 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 healthcare providers after considering the same types of transactions as with an estimated price.

Estimated pricing and average pricing also consider adjustments to correct for over or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price BCBSOK has used for your claim because they will not be applied after a claim has already been paid.

Negotiated Arrangements

With respect to one or more Host Blues, instead of using the BlueCard® Program, BCBSOK may process your claims for covered healthcare services through negotiated arrangements for national accounts.

The amount you pay for covered healthcare services will be calculated based on the lower of either billed charges for covered healthcare services or negotiated price (refer to the description of negotiated price under the BlueCard® Program section above) that the Host Blue makes available to BCBSOK.

Where the employer group agrees to use reference-based benefits, which are service-specific benefit dollar limits for specific procedures, based on a Host Blue's local market rates, you will be responsible for the amount that the healthcare provider bills for a specified procedure above the reference benefit limit for that procedure. For a participating provider, that amount will be the difference between the negotiated price and the reference benefit limit. For a nonparticipating provider, that amount will be the difference between the provider's billed charge and the reference benefit limit. Where a reference benefit limit exceeds either a negotiated price or a provider's billed charge, you will incur no liability, other than any applicable patient cost sharing under this agreement.

Special Cases: Value-Based Programs

If you receive covered healthcare services under a value-based program inside a Host Blue's service area, you will not be responsible for paying any of the provider incentives, risk-sharing and/or care coordinator fees that are a part of such an arrangement, except when a Host Blue passes these fees to BCBSOK through average pricing or fee schedule adjustments.

Value-Based Programs: Negotiated Arrangements

If BCBSOK has entered a negotiated arrangement with a Host Blue to provide value-based programs to your employer on your behalf, BCBSOK will follow the same procedures for value-based programs administration and care coordinator fees, as noted above, for the BlueCard® Program.

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

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

Nonparticipating Providers Outside BCBSOK's Service Area

Member Liability Calculation

When covered healthcare services are provided outside of BCBSOK's service area by nonparticipating providers, the amount(s) you pay for such services will be calculated using the methodology described in the certificate for noncontracting providers located inside BCBSOK's service area or the pricing arrangements required by applicable law. In these situations, you may be responsible for the difference between the amount that the nonparticipating provider bills and the payment BCBSOK will make for the covered healthcare services as set forth in this paragraph. Payments for out-of-network emergency services, certain services provided by out-of-network providers at in-network facilities, and out-of-network air ambulance services will be governed by applicable federal and state law.

In certain situations, BCBSOK may use other payment methods, such as billed charges for covered healthcare services, the payment BCBSOK would make if the healthcare services had been obtained within BCBSOK's service area, or a special negotiated payment to determine the amount BCBSOK will pay for services provided by nonparticipating providers. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment BCBSOK will make for the covered healthcare services as set forth in this paragraph.

Blue Cross Blue Shield Global® Core (Blue Cross Blue Shield Global Solutions℠)

If you are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, (hereinafter: "BlueCard® service area"), you may be able to take advantage of Blue Cross Blue Shield Global® Core when accessing covered healthcare services. Blue Cross Blue Shield Global® Core is unlike the BlueCard® Program available in the BlueCard® service area in certain ways. For instance, although Blue Cross Blue Shield Global® Core assists you with accessing a network of inpatient, outpatient and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the BlueCard® service area, you will

typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

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

- **Inpatient Services**

  In most cases, if you contact the service center for assistance, hospitals will not require you to pay for covered inpatient services, except for your cost-share amounts/deductibles, coinsurance, etc. In such cases, the hospital will submit your claims to the service center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for covered healthcare 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 healthcare services.

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

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

MEMBER REWARDS

Member Rewards is a free**,** voluntary program in which eligible Participants can earn a percentage of the claim savings in the form of a cash reward by selecting quality, low-cost Network facilities for qualified elective, non-emergency medical services. Participants can use the Provider Finder tool on our website at https://www.bcbsok.com/find-care/find-a-doctor-or-hospital to find a list of all eligible services and facility options. Shopping can also be conducted by calling customer service, who will shop for services and facilities on your behalf.

When you choose a rewards eligible service, you will earn a portion of the savings in the form of a check mailed to you, usually within 60 days. This reward is separate from and does not affect your claim for a qualified service. To earn a reward, you must:

- have active coverage on the date you shop for a rewards-eligible service;
- have active coverage on the date the medical service is rendered; and
- complete the rewards-eligible service within thirteen months of shopping.

Incentive amounts and eligible services are subject to change; however, the maximum reward amount you may earn on any single procedure is $500. Any reward amounts received may be taxable.

Your Provider may refer you to a facility or location to complete your medical service or procedure that is not eligible for a reward. However, you must use a facility that is eligible for the program to receive a reward. If your Provider refers you to a facility that is not eligible for a reward under the program, customer service may be able to

coordinate with your Provider to find an eligible facility or location, if one is available. Remember, all decisions on where to receive care are between you and your Provider.

Member Rewards is not a discount program and will not impact Benefits or claims processing. The Plan may discontinue or change this program upon 180 days' notice to Participants. To maintain eligibility for a reward, you must complete shopping for a rewards-eligible service prior to the program termination following such notice. Rewards may be paid out up to 90 days after program termination. All rewards earned under this program will be funded by BCBSOK, and subject to the provided provisions of this program and all other applicable articles of coverage including payment of Benefits, termination of coverage, and review of claim determinations. A Referral or Prior Authorization may be required for your procedure or service.

If you have questions about this program, call customer service or visit our website at www.bcbsok.com.

DETERMINATION OF BENEFITS AND UTILIZATION REVIEW

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

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

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

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

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

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

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

RESCISSION OF COVERAGE

Rescission is the retroactive cancellation or discontinuance of coverage due to an act, practice, or omission that constitutes fraud or an intentional misrepresentation of a material fact by you or by a person seeking coverage on your behalf. A retroactive cancellation or discontinuance of coverage due to failure to timely pay required premiums or contributions toward the cost of coverage (including COBRA premiums), a cancellation or discontinuance initiated by you or your authorized representative or a prospective cancellation or discontinuance of coverage is not considered a rescission. Rescission is subject to 30 days' prior notification and is retroactive to the Effective Date. In the event of such cancellation, the Plan may deduct from the premium refund any amounts made in claim payments during this period, and you may be liable for any claims payment amount greater than the total amount of premiums paid during the period for which cancellation is affected. At any time when the Plan is entitled to rescind coverage already in force or is otherwise permitted to make retroactive changes to this Certificate, the Plan

may at its option make an offer to reform the Certificate already in force and/or change the rating category/level. In the event of reformation, the Certificate will be reissued retroactive in the form it would have been issued had the misstated or omitted information been known at the time of application. Please call a Customer Service Representative at the toll-free number listed on the back of your Identification Card for additional information regarding your appeal rights concerning rescission and/or reformation. If the decision to rescind coverage is upheld at the completion of the internal appeal process, external review by an Independent Review Organization may be requested.

SUBSCRIBER/PROVIDER RELATIONSHIP

The choice of a Provider is solely yours.

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

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

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

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

GROUP RELATIONSHIPS

The Group is your agent, not our agent.

VALUE-BASED DESIGN PROGRAMS

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

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

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

IDENTITY THEFT PROTECTION SERVICES

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

ACTUARIAL VALUE

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

COORDINATION OF BENEFITS

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

- **Definitions**

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

  "Other Contract" means any arrangement, providing health care Benefits or services through:

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

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

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

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

- **Effect On Benefits**

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

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

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

- **Order of Benefit Determination**

  - When a person who received care is covered as an Employee under one Group Contract, and as a Dependent under another, then the Employee coverage pays first.
  - When a Dependent child is covered under two Group Contracts, the Contract covering the child as a

Dependent of the parent whose birthday falls earliest in the Calendar Year pays first. (If one Contract does not follow the "birthday rule" provision, then the rule followed by that Contract is used to determine the order of Benefits.)

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

- If the parent with custody of the child has not remarried, the coverage of the parent with custody pays first.
- When a divorced parent with custody has remarried, the coverage of the parent with custody pays first and the stepparent's coverage pays second before the coverage of the parent who does not have custody.
- Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses, the coverage of that parent pays first.

- When none of the above circumstances applies, the coverage you have had for the longest time pays first, except that a Contract which covers you as a laid-off or retired Employee or as a Dependent of such person pays after a Contract which covers you as other than a laid-off or retired Employee or Dependent of such person.
- When the Plan requests information from another carrier to determine the extent or order of your Benefits under an Other Contract, and such information is not furnished after a reasonable time, then the Plan shall:
  - assume the Other Contract is required to determine its Benefits first;
  - assume the Benefits of the Other Contract are identical to the Benefits of this coverage and pay its Benefits accordingly.

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

- **Facility of Payment**

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

- **Right of Recovery**

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

PLAN'S RIGHT OF RECOUPMENT

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

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

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

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

  - any future Benefit payment made to any person or entity under this Certificate, whether for the same or a different Subscriber; or
  - any future Benefit payment made to any person or entity under a self-funded Benefit program administered by the Plan; or
  - any future Benefit payment made to any person or entity under another Group Benefit Plan or individual policy insured by the Plan; or
  - any future Benefit payment, or other payment, made to any person or entity; or
  - any future payment owed to one or more Participating Providers or Out-of-Network Providers.

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

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

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

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

LIMITATIONS ON PLAN'S RIGHT OF RECOUPMENT/RECOVERY

The Plan will not seek recovery of all or a portion of a payment of a claim made to a Subscriber more than six (6) months or a Provider more than twelve (12) months after the payment is made. This paragraph shall not apply:

– if the payment was made because of fraud committed by the Subscriber or the Provider; or

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

THE PLAN'S SEPARATE FINANCIAL ARRANGEMENTS WITH PRESCRIPTION DRUG PROVIDERS

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

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

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

The amounts received by Prime from the Plan, Pharmacies, manufacturers or other third parties may be revised from time to time. Some of the amounts received by Prime may be charged each time a claim is processed (or, in some instances, requested to be processed) through Prime and/or each time a prescription is filled, and include, but are not limited to, administrative fees charged by Prime to the Plan (as described above), administrative fees charged by Prime to Pharmacies, and administrative fees charged by Prime to pharmaceutical manufacturers. Currently, none of these fees will be passed on to you as expenses, or accrue to the Benefit of you, unless otherwise specifically set forth in this Certificate. Additional information about these types of fees or the amount of these fees is available upon request. The maximum that Prime will receive from any pharmaceutical manufacturer for certain

administrative fees will be 3% of the total sales for all rebateable 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 MANAGER

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.

Subscriber Rights and Responsibilities

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 and responsibilities.

1. A right to receive information about the organization, its services, its practitioners and Providers and Member rights and responsibilities.
2. A right to be treated with respect and recognition of their dignity and their right to privacy.
3. A right to participate with practitioners in making decisions about their health care.
4. A right to a candid discussion of appropriate or Medically Necessary treatment options for their conditions, regardless of cost or Benefit coverage.
5. A right to voice complaints or appeals about the organization or the care it provides.
6. A right to make recommendations regarding the organization's Member rights and responsibilities policy.
7. A responsibility to supply information (to the extent possible) that the organization and its practitioners and Providers need in order to provide care.
8. A responsibility to follow plans and instructions for care that they have agreed to with their practitioners.
9. A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

Claims Filing Procedures

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

PARTICIPATING PROVIDERS

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

REMEMBER...

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

PRESCRIPTION DRUG CLAIMS

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

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

HOSPITAL CLAIMS

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

AMBULATORY SURGICAL FACILITY AND OTHER FACILITY CLAIMS

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

PHYSICIAN AND OTHER PROVIDER CLAIMS

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

MEMBER-FILED CLAIMS

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

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

Blue Cross and Blue Shield of Oklahoma
PO Box 655924
Dallas, TX 75265-5924

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

Prime Therapeutics
PO Box 25136
Lehigh Valley, PA 18002-5136

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

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

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

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

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

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

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

BENEFIT DETERMINATIONS FOR PROPERLY FILED CLAIMS

Once the Plan receives a Properly Filed Claim from you or your Provider, a Benefit determination will be made 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.***

DIRECT CLAIMS LINE

We have a direct line for claims and membership inquiries. You may call the number shown on your Identification Card between 8:00 a.m. and 6:00 p.m., Monday through Friday, whenever you have a question concerning a claim or your membership.

Complaint/Appeal Procedure

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

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

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

CLAIM DETERMINATIONS

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

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

IF A CLAIM IS DENIED OR NOT PAID IN FULL

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

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

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

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

TIMING OF REQUIRED NOTICES AND EXTENSIONS

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

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

URGENT CARE CLAIMS*

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

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

PRE-SERVICE CLAIMS

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

POST-SERVICE CLAIMS

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

CLAIM APPEAL PROCEDURES

- ***Claim Appeal Procedures – Definitions***

  An **"Adverse Benefit Determination"** means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Benefit, including any such denial, reduction, termination, or failure to provide or make payment for, a Benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which Benefits are otherwise provided because it is determined to be Experimental, Investigational and/or Unproven or not Medically Necessary or appropriate. If an ongoing course of treatment had been approved by the Plan and the Plan reduces or terminates such treatment (other than by amendment or termination of this Certificate) before the end of the approved treatment period, that is also an Adverse Benefit Determination.

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

- ***Urgent Care/Expedited Clinical Appeals***

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

  Upon receipt of an expedited pre-service or concurrent clinical appeal, we will notify the party filing the appeal, as soon as possible, but no more than 24 hours after submission of the appeal, of all the information needed to review the appeal. Additional information must be submitted within 24 hours of request. The Plan shall render a determination on the appeal as soon as possible (taking into account medical exigencies) but no later than 72 hours after it receives the initial request, or within 48 hours after it receives the missing information (if the initial request is incomplete).

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

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

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

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

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

    Appeal Coordinator – Customer Service Department
    Blue Cross and Blue Shield of Oklahoma

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

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

- ***Timing of Appeal Determinations***

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

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

- ***Notice of Appeal Determination***

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

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

  - A reason for the determination;
  - A reference to the Benefit provisions on which the determination is based, or the Contractual or administrative basis or protocol for the determination;
  - Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care Provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
  - An explanation of our external review processes (and how to initiate an external review);
  - In certain situations, a statement in non-English language(s) that the written notice of the claim denial and certain other Benefit information may be available (upon request) in such non-English language(s);

- In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by us;
- The right to request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for Benefits;
- Any internal rule, guideline, protocol, or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge on request;
- An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;
- A description of the standard that was used in denying the claim and a discussion of the decision; and
- Contact information for applicable office of health insurance consumer assistance or ombudsman.

EXTERNAL REVIEW RIGHTS

If you receive an Adverse Benefit Determination, you may have a right to have our decision reviewed by independent health care professionals who have no association with us ***if our decision involved making a judgment as to the Medical Necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment.*** The request for a standard external review by an Independent Review Organization (IRO) must be submitted within four months after you receive notice of the internal appeal determination. For a standard external review, a decision will be made within **45 days** of receiving your request. If you have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed, you may request an **expedited external review** of our denial before your internal review rights have been exhausted. If our denial to provide or pay for a health care service or course of treatment is based on a determination that the service or treatment is Experimental, Investigational or Unproven, you also may be entitled to file a request for external review of our denial.

You or your authorized representative may file a request for a standard or expedited external review by completing the required forms and submitting them directly to the address noted below. We will also provide the forms to you upon request.

Oklahoma Insurance Department
PO Box 53408
Oklahoma City, OK 73152-3408
Telephone: 1-800-522-0071
(Oklahoma only) 405-521-2828

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

For questions about your rights or for additional assistance, you may contact the Oklahoma Consumer Assistance Program at:

Oklahoma Insurance Department
400 NE 50th Street
Oklahoma City, OK 73105
http://www.oid.ok.gov/consumers/external-review-process
Telephone: 1-800-522-0071 or 405-521-2828

Your ERISA Rights

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

ERISA RIGHTS

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

ASSISTANCE WITH YOUR QUESTIONS

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

Definitions

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

ALLOWABLE CHARGE

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

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

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

AMBULATORY SURGICAL FACILITY

A Provider with an organized staff of Physicians which:

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

APPLIED BEHAVIOR ANALYSIS

The design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce social significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

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.

BIOMARKER TESTING

The analysis of tissue, blood, or other biospecimen for the presence of a biomarker, including single-analyte tests, multiplex panel tests, gene or protein expression, and whole exome, whole genome, and whole transcriptome sequencing.

BLUECARD PROVIDER

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

BRAND DRUG (NON-PREFERRED)

A brand-name Prescription Drug which appears on the applicable Drug List and is identified as a Non-Preferred Brand Name Drug. The Drug List is available on the Plan's website at https://www.bcbsok.com/prescription-drugs/managing-prescriptions/drug-lists.

BRAND DRUG (PREFERRED)

A brand-name Prescription Drug which appears on the applicable Drug List and is identified as a Preferred Brand Name Drug. The Drug List is available on the Plan's website at https://www.bcbsok.com/prescription-drugs/managing-prescriptions/drug-lists.

CALENDAR YEAR

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

CARE COORDINATION

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

CARE COORDINATOR FEE

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

COBRA CONTINUATION COVERAGE

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

COINSURANCE

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

CONTRACT/GROUP CONTRACT

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

COPAYMENT

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

COVERED DRUG

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

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

COVERED SERVICE

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

CUSTODIAL CARE

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

DEDUCTIBLE

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

DEPENDENT

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

DIAGNOSTIC SERVICE

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

- Radiology, ultrasound, and nuclear medicine;
- Laboratory and pathology;

- ECG, EEG and other electronic diagnostic medical procedures and physiological medical testing, as determined by the Plan.

DOMESTIC PARTNER

A companion of the same sex or opposite sex with whom the Member has entered into a Domestic Partnership in accordance with the Employer's guidelines. All provisions of this Certificate (with the exception of COBRA Continuation Coverage), that pertain to a spouse also pertain to a Domestic Partner once eligibility is determined. Check with your Group Administrator for Domestic Partner provisions unique to your Group's coverage.

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

DOMESTIC PARTNERSHIP

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

DRUG LIST

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

DURABLE MEDICAL EQUIPMENT

Equipment which meets the following criteria:

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

EFFECTIVE DATE

The date when your coverage begins.

ELIGIBLE PERSON

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

EMERGENCY CARE

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

- serious jeopardy to the Subscriber's health (or, with respect to a pregnant individual, the health of the individual or their unborn child);
- serious impairment to bodily function; or

- serious dysfunction of any bodily organ or part; or
- with respect to a pregnant individual 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 individual 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.

EMPLOYEE

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

EMPLOYER

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

EXPERIMENTAL/INVESTIGATIONAL/UNPROVEN

A drug, device or supply (including emerging technologies, services, procedures, and service paradigms), biological product or medical treatment or procedure is Experimental, Investigational and/or Unproven if **the Plan determines** that:

- the drug, device or supply (including emerging technologies, services, procedures, and service paradigms), 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 or supply (including emerging technologies, services, procedures, and service paradigms), 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 or supply (including emerging technologies, services, procedures, and service paradigms), 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. Prescription Drugs that are approved by the FDA through the accelerated approval program may be considered Experimental/Investigational/Unproven.

GENERIC DRUG

A drug that has the same active ingredient as a brand-name drug and is allowed to be produced after the brand-name drug's patent has expired. To determine which drugs are Generic Drugs (Preferred) or Generic Drugs (Non-Preferred), refer to the Drug List on the Plan's website at https://www.bcbsok.com/prescription-drugs/managing-prescriptions/drug-lists. You may also contact a Customer Service Representative at the number shown on your Identification Card for more information. All products identified as a Generic Drug by the drug product database, manufacturer, Pharmacy, or your Physician may not be considered a Generic Drug by the Plan.

GENERIC DRUG (NON-PREFERRED)

A Generic Drug which appears on the applicable Drug List and is identified as a Non-Preferred Generic Drug. The Drug List is available on the Plan's website at https://www.bcbsok.com/prescription-drugs/managing-prescriptions/drug-lists.

GENERIC DRUG (PREFERRED)

A Generic Drug which appears on the applicable Drug List and is identified as a Preferred Generic Drug. The Drug List is available on the Plan's website at https://www.bcbsok.com/prescription-drugs/managing-prescriptions/drug-lists.

GROUP

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

GROUP HEALTH PLAN

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

HABILITATION CARE

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

HOME HEALTH CARE AGENCY

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

HOSPICE

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

HOSPITAL

A facility licensed as a Hospital as required by law, which is primarily engaged in providing diagnostic and therapeutic facilities for the treatment of care of injured and sick persons, by or under the supervision of a staff of Physicians who are duly licensed to practice medicine and Surgery, and which continuously provides 24-hour a day nursing services.

HOSPITAL ADMISSION

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

IATROGENIC INFERTILITY

An impairment of fertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment, affecting reproductive organs or processes.

IDENTIFICATION CARD

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

INPATIENT

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

INTENSIVE OUTPATIENT TREATMENT

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

LEGEND DRUGS

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

LICENSED PRACTICAL OR VOCATIONAL NURSE (LPN OR LVN)

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

LIFE-THREATENING DISEASE OR CONDITION

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

MAINTENANCE PRESCRIPTION DRUG

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

MATERNITY SERVICES

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

MEDICAL CARE

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

MEDICALLY NECESSARY (OR MEDICAL NECESSITY)

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

- in accordance with generally accepted standards of medical practice;

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

MEDICARE

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

MEMBER

An Eligible Person who has enrolled for coverage.

MENTAL HEALTH AND SUBSTANCE USE DISORDER

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

NETWORK PROVIDER

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

NETWORK SERVICE AREA

The geographic area designated by the Plan, that the Subscribers must reside, live, or work in to be eligible to apply for coverage under this Certificate. A Subscriber may call the Customer Service Department at the number shown on the Identification Card to determine if he or she is in the Network Service Area or visit the website at www.bcbsok.com.

ORTHOGNATHIC SURGERY

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

OUT-OF-NETWORK PHARMACY

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

OUT-OF-NETWORK PROVIDER

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

OUT-OF-POCKET LIMIT

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

The Out-of-Pocket Limit does not include services received from Out-of-Network Providers, amounts in excess of the Allowable Charge, or charges for any services that are not covered under this Certificate.

OUTPATIENT

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

PARTICIPATING PHARMACY

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

To find a Pharmacy in the Participating Pharmacy Network, please refer to the Plan's website at https://www.bcbsok.com/provider_finder/important_info_rx.html or call a Customer Service Representative at the number shown on your Identification Card.

PARTICIPATING SPECIALTY PHARMACY

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

PHARMACY

A state and federally licensed establishment that is physically separate and apart from any Provider's office, and where Legend Drugs and devices are dispensed under Prescription Orders to the general public by a pharmacist licensed to dispense such drugs and devices under the law of the state in which he or she practices.

PHYSICIAN

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

PLACEMENT FOR ADOPTION (OR PLACED FOR ADOPTION)

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

PLAN

Blue Cross and Blue Shield of Oklahoma.

POST-SERVICE MEDICAL NECESSITY REVIEW

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

PREFERRED PARTICIPATING PHARMACY

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

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

PRESCRIPTION DRUG

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

PRESCRIPTION ORDER

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

PREVENTIVE CARE SERVICES

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

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

PRIOR AUTHORIZATION

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

PROPERLY FILED CLAIM

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

PROVIDER

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

PROVIDER INCENTIVE

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

PSYCHIATRIC HOSPITAL

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

QUALIFYING EVENT

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

- the death of the covered Employee;

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

REGISTERED NURSE (RN)

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

REHABILITATION CARE

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

RESIDENTIAL TREATMENT CENTER (RTC)

A facility setting offering a defined course of therapeutic interventions and special programming in a controlled environment which also offers a level of security, supervision, and structure Medically Necessary to meet the needs of patients served or to be served by such facility. To qualify as a Residential Treatment Center, patients must be medically monitored with a 24-hour medical professional availability and on-site nursing care and supervision for a least one shift a day with on call availability for the other shifts. Residential Treatment Centers must be licensed by the appropriate state and local authority as a Residential Treatment Facility or its equivalent under the laws or regulations of such locality and/or must be accredited by a national accrediting body as a Residential Treatment Center or its equivalent.

Accepted accrediting bodies are The Joint Commission, Commission on Accreditation of Rehabilitation Facilities (CARF), Accreditation Association for Ambulatory Healthcare (AAAHC), Council on Accreditation of Services for Families and Children Inc. (COA), or National Integrated Accreditation of Healthcare Organizations (NIAHOSM). This includes any specialized licensing that may be applicable given the services to be provided or the population to be served.

As they do not provide the level of care, security, or supervision appropriate of a Residential Treatment Center, the following shall not be included in the definition of Residential Treatment Center:

- Half-way houses;
- Supervised living;
- Group homes;
- Wilderness programs;
- Boarding houses; or
- Other facilities that provide primarily a supportive/custodial environment and/or primarily address long term social needs, even if counseling is provided in such facilities.

RETAIL HEALTH CLINIC

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

RETAIL PHARMACY VACCINATION NETWORK

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

ROUTINE NURSERY CARE

Ordinary Hospital nursery care of the newborn Subscriber.

SKILLED NURSING FACILITY

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

- custodial care, ambulatory, or part-time care; or
- treatment for Mental Health and Substance Use Disorder or pulmonary tuberculosis.

SPECIALIST

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

SPECIALTY DRUG (NON-PREFERRED)

A Specialty Drug which appears on the applicable Drug List and is identified as a Non-Preferred Specialty Drug. The Drug List is available on the Plan's website at https://www.bcbsok.com/prescription-drugs/managing-prescriptions/drug-lists.

SPECIALTY DRUG (PREFERRED)

A Specialty Drug which appears on the applicable Drug List and is identified as a Preferred Specialty Drug. The Drug List is available on the Plan's website at https://www.bcbsok.com/prescription-drugs/managing-prescriptions/drug-lists.

SPECIALTY PHARMACY DRUGS

Prescription Drugs that are high cost and generally prescribed for use in limited patient populations or indications. These drugs are typically injected but may also include high-cost oral medications. In addition, patient support and/or education and special dispensing or delivery may be required for these drugs; therefore, they are difficult to obtain via traditional Pharmacy channels. To determine which drugs are Preferred Specialty Drugs or Non-Preferred Specialty Drugs, refer to the Drug List on the Plan's website at https://www.bcbsok.com/prescription-drugs/managing-prescriptions/drug-lists or call the Customer Service toll-free number on your Identification Card.

SPECIALTY PHARMACY NETWORK

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

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

STANDARD FERTILITY PRESERVATION SERVICES

Oocyte and sperm preservation procedures, including ovarian tissue, sperm, and oocyte cryopreservation, that are consistent with established medical practices or professional guidelines published by the American Society of

Clinical Oncology or the American Society for Reproductive Medicine; provided, however, standard fertility preservation services shall not include storage.

SUBSCRIBER

The Member and each of their Dependents (if any) covered under this Certificate.

SURGERY

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

TELEMEDICINE VISITS

The diagnosis, consultation or treatment provided by a licensed Provider through one or more technology-enabled health and care management and delivery systems that extend capacity and access to care.

THERAPY SERVICE

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

- **Radiation Therapy** – the treatment of disease by x-ray, radium, or radioactive isotopes.
- **Chemotherapy** – the treatment of malignant disease by chemical or biological antineoplastic agents, but not including High-Dose Chemotherapy. High-Dose Chemotherapy is specifically addressed in certain sections under "Human Organ, Tissue and Bone Marrow Transplant Services".
- **Respiratory Therapy** – introduction of dry or moist gases into the lungs for treatment purposes.
- **Dialysis Treatment** – the treatment of an acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body to include hemodialysis or peritoneal dialysis.
- **Infusion Therapy –** the administration of medication through a needle or catheter. Typically, "Infusion Therapy" means that a drug is administered intravenously, but the term also may refer to situations where drugs are provided through other non-oral routes, such as intramuscular injections and epidural routes (into the membranes surrounding the spinal cord). Infusion Therapy is prescribed when a patient's condition is so severe that it cannot be treated effectively by oral medications.
- **Physical Therapy –** the treatment by physical means, hydrotherapy, heat or similar modalities, physical agents, bio-mechanical and neuro-physiological principles, and devices to relieve pain, to restore, attain or maintain maximum function, and to prevent disability or deterioration of a skill or function resulting from a disabling condition, disease, injury, or loss of body part.
- **Occupational Therapy -** treatment of a physically disabled person by means of constructive activities designed and adapted to promote the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role.
- **Speech Therapy –** treatment for the correction of a speech impairment resulting from disease, Surgery, injury, congenital and developmental anomalies, or previous therapeutic processes.
- **Manipulative Therapy** – hands on treatment of muscles, tendons, ligaments and joint disorders by chiropractic or osteopathic manual therapy.

TOBACCO USER

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

TOTAL DISABILITY (OR TOTALLY DISABLED)

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

- the Subscriber is unable to perform the substantial duties of any occupation or business for which they are 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.

VALUE-BASED DESIGN PROGRAM

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

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 during a Special Enrollment Period, any period before such special enrollment is not a Waiting Period.

BlueCross BlueShield
of Oklahoma

1400 South Boston • Tulsa, OK 74102
PO Box 655924 • Dallas, TX 75265-5924

PEDIATRIC DENTAL SERVICES ADDENDUM

For Subscribers Under Age 19

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

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

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

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

DEFINITIONS

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

- **Allowable Charge –** The charge that the Plan will use as the basis for Benefit determination for Covered Services you receive under the Certificate and this Addendum. The Plan will use the following criteria to establish the Allowable Charge for Covered Dental Services:
  - **Participating Dentist** – the amount the Dentist has agreed to accept as full payment for Covered Services.
  - **Out-of-Network Dentists** – the Dentist's usual charge for Covered Services, not to exceed the amount that the Plan would reimburse a Participating Dentist for the same services. The Subscriber may be responsible for the full amount by which the actual charges of an Out-of-Network Dentist exceed the Allowable Charge.
- **Course of Treatment –** Any number of dental procedures or treatments performed by a Dentist or Physician in a planned series. In cases where there is more than one professionally acceptable Course of Treatment or service to treat the dental condition, Benefits will be covered for the least costly Course of Treatment or service.

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

ELIGIBILITY

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

SCHEDULE OF BENEFITS
FOR
PEDIATRIC DENTAL SERVICES

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

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

Benefit Period	Calendar Year
Deductible	Your Benefits for Pediatric Dental Services are subject to the Benefit Period Deductible for *"Network Provider Services"* set forth in the ***Schedule of Benefits for Comprehensive Health Care Services.***
Benefit Period Maximum	Unlimited
Out–of–Pocket Limit	Your Benefits for Pediatric Dental Services are subject to the Out-of-Pocket Limit for *"Blue Choice Provider Services"* set forth in the ***Schedule of Benefits for Comprehensive Health Care Services.***

Benefit Percentage Amount	The following chart shows the percentage of Allowable Charges covered by this Addendum through payments and/or contractual arrangements with Providers. These percentages apply only after your Deductible amounts have been satisfied.	
COVERED SERVICES	**BENEFIT PAYABLE**	
	Services obtained from a Participating Dentist	**Services obtained from an Out-of-Network Dentist***
Diagnostic Evaluations	70% of Allowable Charge	50% of Allowable Charge
Preventive Services (Periodic Oral Evaluation and Topical Fluoride Application covered at 100%, Deductible waived)	70% of Allowable Charge	50% of Allowable Charge
Diagnostic Radiographs	70% of Allowable Charge	50% of Allowable Charge
Miscellaneous Preventive Services	70% of Allowable Charge	50% of Allowable Charge
Basic Restorative Services	70% of Allowable Charge	50% of Allowable Charge
Non-Surgical Extractions	70% of Allowable Charge	50% of Allowable Charge
Non-Surgical Periodontal Services	70% of Allowable Charge	50% of Allowable Charge
Adjunctive General Services	70% of Allowable Charge	50% of Allowable Charge
Endodontic Services	70% of Allowable Charge	50% of Allowable Charge
Oral Surgery Services	70% of Allowable Charge	50% of Allowable Charge
Surgical Periodontal Services	70% of Allowable Charge	50% of Allowable Charge
Major Restorative Services	70% of Allowable Charge	50% of Allowable Charge
Prosthodontic Services	70% of Allowable Charge	50% of Allowable Charge
Miscellaneous Restorative and Prosthodontic Services	70% of Allowable Charge	50% of Allowable Charge
Orthodontic Services		
Pediatric Orthodontic Services: Coverage limited to Subscribers with an orthodontic condition meeting Medical Necessity criteria established by the Plan (e.g., severe, dysfunctional malocclusion)	70% of Allowable Charge (Unlimited Lifetime Maximum)	50% of Allowable Charge (Unlimited Lifetime Maximum)

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

Pediatric Dental Services

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

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

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

COVERED DENTAL SERVICES:

DIAGNOSTIC EVALUATIONS

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

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

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

PREVENTIVE SERVICES

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

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

Special Provisions Regarding Preventive Services

Cleanings include associated scaling and polishing procedures.

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

DIAGNOSTIC RADIOGRAPHS

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

- Full-mouth (intraoral complete series) and panoramic films – Benefits are limited to a combined maximum of one every 36 months.

- Bitewing films – Benefits are limited to two sets every 12 months.
- Intraoral periapical films, as Medically Necessary for diagnosis.

MISCELLANEOUS PREVENTIVE SERVICES

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

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

BASIC RESTORATIVE SERVICES

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

- Amalgam restorations.
- Resin-based composite restorations.

NON-SURGICAL EXTRACTIONS

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

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

NON-SURGICAL PERIODONTAL SERVICES

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

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

ADJUNCTIVE GENERAL SERVICES

Adjunctive General Services include:

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

ENDODONTIC SERVICES

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

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

ORAL SURGERY SERVICES

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

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

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

SURGICAL PERIODONTAL SERVICES

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

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

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

MAJOR RESTORATIVE SERVICES

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

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

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

PROSTHODONTIC SERVICES

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

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

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

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

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

MISCELLANEOUS RESTORATIVE AND PROSTHODONTIC SERVICES

Other restorative and prosthodontic services include:

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

- Repairs of inlays, onlays, veneers, crowns, fixed or removable dentures, including replacement or addition of missing or broken teeth or clasp.

MEDICALLY NECESSARY ORTHODONTIC SERVICES

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

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

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

Covered orthodontic services include:

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

Special Provisions Regarding Orthodontic Services:

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

EXCLUSIONS AND LIMITATIONS

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

Important Information About Your Dental Benefits

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

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

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

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

- **Care By More Than One Dentist**

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

- **Alternate Benefits**

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

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

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

- **Non-Compliance with Prescribed Care**

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

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

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

Exclusions — What Is Not Covered

No Benefits will be provided under this Addendum for:

- Services or supplies not specifically listed as a Covered Service, or when they are related to a non-covered service.
- Amounts which are in excess of the Allowable Charge, as determined by the Plan.
- Dental services for treatment of congenital or developmental malformation, or services performed for cosmetic purposes, including but not limited to bleaching teeth, lack of enamel and grafts to improve aesthetics except as described in the pediatric Medically Necessary orthodontic Benefit as shown in Medically Necessary Orthodontic Services.
- Dental services or appliances for the diagnosis and/or treatment of temporomandibular joint dysfunction and related disorders, unless specifically mentioned in this Addendum or if resulting from accidental injury. Dental services or appliances to increase vertical dimension, unless specifically mentioned in this Addendum.
- Dental services which are performed due to an accidental injury. Injury caused by chewing or biting an object or substance placed in your mouth is not considered an accidental injury.

- Services and supplies for any illness or injury suffered after the Subscriber's Effective Date as a result of war or any act of war, declared or undeclared, when serving in the military or any auxiliary unit thereto.
- Services or supplies that do not meet accepted standards of dental practice.
- Experimental, Investigational and/or Unproven services and supplies and all related services and supplies.
- Hospital and ancillary charges.
- Implants and any related services and supplies (other than crowns, bridges and dentures supported by implants) associated with the placement and care of implants.
- Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.
- Services or supplies for which "discounts" or waiver of Deductible or Coinsurance amounts are offered.
- Services rendered by a Dentist related to you by blood or marriage.
- Services or supplies received from someone other than a Dentist, except for those services received from a licensed dental hygienist under the supervision and guidance of a Dentist, where applicable.
- Claims for a service which is for the same service performed on the same date for the same Subscriber.
- Services or supplies received for behavior management or consultation purposes.
- Any illness or injury occurring in the course of employment if whole or partial compensation or benefits are or might have been available under the laws of any governmental unit; any policy of workers' compensation insurance; an employer's insured and/or self-funded workers' compensation plan or any other plan providing coverage for work-related illness or injury; or according to any recognized legal remedy arising from an employer-employee relationship. This applies whether or not you claim the benefits or compensation or recover the losses from a third party.
  - You agree to:
    - pursue your rights under the workers' compensation laws;
    - take no action prejudicing the rights and interests of the Plan; and
    - cooperate and furnish information and assistance the Plan requires to help enforce its rights.
  - If you receive any money in settlement of your employer's liability, regardless of whether the settlement includes a provision for payment of your medical bills, you agree to:
    - hold the money in trust for the benefit of the Plan to the extent that the Plan has paid any Benefits or would be obligated to pay any Benefits; and
    - repay the Plan any money recovered from the employer or insurance carrier.
- Any services or supplies to the extent payment has been made under Medicare or to the extent governmental units provide benefits or would have provided benefits if you had applied for and claimed those benefits (some state or federal laws may affect how we apply this exclusion).
- Charges for nutritional or oral hygiene counseling.
- Charges for local, state or territorial taxes on dental services or procedures.
- Charges for the administration of infection control procedures as required by local, state or federal mandates.
- Charges for duplicate, temporary or provisional prosthetic device or other duplicate, temporary or provisional appliances.
- Charges for telephone consultations, email or other electronic consultations, missed appointments, completion of a claim form or forwarding requested records or x-rays.
- Charges for prescription or non-prescription mouthwashes, irrigation mouth rinses, topical solutions, preparations or medicament carriers.

- Charges for personalized restorations, or personalized complete or partial dentures and overdentures, or to employ specialized techniques for dental services rather than professionally accepted, necessary and appropriate treatment; except this exclusion will not apply to the Benefits provided for the Covered Services subject to the Alternate Benefit provision.
- Charges for athletic mouth guards, isolation of tooth with rubber dam, metal copings, mobilization of erupted/malpositioned tooth, precision attachments for partials and/or dentures and stress breakers.
- Any services, treatments or supplies included as Covered Services under other hospital, medical and/or surgical coverage.
- Case presentations or detailed and extensive treatment planning when billed for separately.
- Charges for occlusion analysis, diagnostic casts or occlusal adjustments.
- Orthodontic treatment that is not Medically Necessary.
- Cone beam imaging and cone beam MRI procedures.
- Sealants for teeth other than permanent molars.
- Localized delivery of antimicrobial agents or chemotherapeutic agents.
- Comprehensive periodontal evaluations or problem-focused evaluations if Covered Services are rendered on the same date as any other oral evaluation and by the same Dentist.
- Tests and oral pathology procedures, or for re-evaluations.
- Any radiographs taken related to the diagnosis of Temporomandibular Joint (TMJ) Dysfunction.
- Nutritional, tobacco and oral hygiene counseling.
- Local anesthesia, therapeutic parenteral drugs, or other drugs or medicaments and/or their application.
- Endodontic retreatments provided within 12 months of the initial endodontic therapy by the same Dentist on the same tooth.
- Pulp vitality tests, endodontic endosseous implants, intentional reimplantations, canal preparation, fitting of preformed dowel and post or post removal.
- Endodontic therapy if you discontinue endodontic treatment.
- Surgical services related to a congenital malformation.
- Prophylactic removal of third molars or impacted teeth (asymptomatic, nonpathological), or for complete bony impactions covered by another benefit plan.
- Excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bones; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation, or excision of the temporomandibular joints.
- Bone grafts in conjunction with extractions, apicoectomy or any non-covered service or non-covered implants.
- Guided tissue regeneration, or for biologic materials to aid in tissue regeneration.
- The replacement of a lost, missing or stolen appliance and those for replacement of appliances that have been damaged due to abuse, misuse, or neglect.
- To alter, restore, or correct vertical dimension of occlusion. Such procedures may include, but are not limited to equilibration dentures, crowns, inlays, onlays, bridgework, or other appliances or services used for the purpose of splinting, alter vertical dimension or to restore occlusion or to correct attrition, abrasion, erosion, or abfractions.

- The restoration of occlusion or incisal edges due to bruxism or harmful habits or to correct attrition, abrasion, abfractions or erosion.
- Splinting of teeth, including double retainers for removable partial dentures and fixed bridgework.
- Recementation of an orthodontic appliance by the same Provider who placed the appliance and/or who is responsible for the ongoing care of the Subscriber.
- Replacement or repair of an orthodontic appliance.
- Orthodontic treatment for dental conditions that are primarily cosmetic in nature or when self-esteem is the primary reason for treatment that is not Medically Necessary.

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

EXTENSION OF YOUR DENTAL BENEFITS IN CASE OF TERMINATION

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

PRETREATMENT ESTIMATE OF BENEFITS AND TREATMENT PLAN

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

HOW TO FILE A CLAIM

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

- **Filing Dental Claims**

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

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

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

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

Blue Cross and Blue Shield of Oklahoma
PO Box 660247
Dallas, TX 75266-0247

Claims must be filed with the Plan within 180 days following the end of the Benefit Period for which the claim is made. Claims not filed within the required time period will not be eligible for payment. Should you have any questions about filing claims, call a Customer Service Representative at 1-888-454-5590 between 8:00 a.m. and 6:00 p.m., Monday through Friday.

- **Dental Claim Review Procedures**

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

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

Blue Cross and Blue Shield of Oklahoma
PO Box 660247
Dallas, TX 75266-0247

You may also designate a representative to act for you in the review procedure. Your designation of a representative must be in writing, as it is necessary to protect against disclosure of information about you except to your authorized representative.

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

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

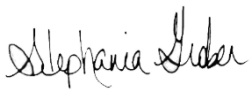
If you have any questions about the claim procedures or the review procedure, you may call a Customer Service Representative at 1-888-454-5590 between 8:00 a.m. and 6:00 p.m., Monday through Friday.

Or, you can write to:

Blue Cross and Blue Shield of Oklahoma
PO Box 660247
Dallas, TX 75266-0247

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

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



President of Blue Cross and Blue Shield of Oklahoma

BlueCross BlueShield
of Oklahoma

1400 South Boston • Tulsa, OK 74102-3283
PO Box 655924 • Dallas, TX 75265-5924

PEDIATRIC VISION CARE ADDENDUM

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

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

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

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

DEFINITIONS

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

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

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

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

ELIGIBILITY

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

SCHEDULE OF BENEFITS

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

SCHEDULE OF BENEFITS FOR PEDIATRIC VISION CARE SERVICES

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

Benefit Period	Calendar Year	
Deductible	Your Benefits for Pediatric Vision Care Services are subject to the Benefit Period Deductible for "Network Provider Services" set forth in the ***Schedule of Benefits for Comprehensive Health Care Services***.	
Out-of-Pocket Limit	Your Benefits for Pediatric Vision Care Services are subject to the Benefit Period Out-of-Pocket Limit for "Network Provider Services" set forth in the ***Schedule of Benefits for Comprehensive Health Care Services***.	
PEDIATRIC VISION CARE BENEFITS		
Pediatric Vision Care Services	**In-Network Subscriber Cost**	**Out-of-Network Allowance**[1]
Exam (with dilation as necessary): *Benefit Period Deductible does not apply.*	No Copayment	$30
Frames: (any available frame at Provider location)		
Provider Designated Frames	No Copayment	$75
Non-Provider Designated Frames	No Copayment up to $150 allowance - you receive 20%[2] off balance over $150	$75

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

Standard Plastic, Glass or Poly Spectacle Lenses:		
Single Vision	No Copayment	$25
Bifocal	No Copayment	$40
Trifocal	No Copayment	$55
Lenticular	No Copayment	$55
Standard Progressive Lens	No Copayment	$55

PEDIATRIC VISION CARE BENEFITS		
Lens Options:		
Ultraviolet Treatment	No Copayment	$12
Tint (Solid and Gradient)	No Copayment	$12
Standard Plastic Scratch Coating	No Copayment	$12
Standard Polycarbonate	No Copayment	$32
Photochromic / Transitions Plastic	No Copayment	$57

Pediatric Vision Care Services	**In-Network Subscriber Cost**	**Out-of-Network Allowance[3]**
Contact Lenses: (Contact lens allowance includes materials only)		
Conventional	No Copayment up to $150 allowance - you receive 15%[4] off balance over $150	$150
Disposable	No Copayment up to $150 allowance	$150
Medically Necessary	No Copayment	$210
NOTE: Additional Benefits over allowance are available from Network Providers except certain retail outlets. Call a Customer Service Representative or visit our website at www.eyemed.com for additional information.		
Routine eye exams do not include professional services for contact lens evaluations. Any applicable fees are the responsibility of the Subscriber.		
Frequency:		
Examination	Once every Calendar Year	
Lenses or Contact Lenses	Once every Calendar Year	
Frames	Once every Calendar Year	

Additional Benefits
Medically Necessary contact lenses: Contact lenses may be determined to be Medically Necessary and appropriate in the treatment of Subscribers affected by certain conditions. In general, contact lenses may be Medically Necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in

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

significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Contact lenses may be determined to be Medically Necessary in the treatment of the following conditions: keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, irregular astigmatism.

Medically Necessary contact lenses are dispensed in lieu of other eyewear. Network Providers will obtain the necessary Preauthorization for these services.

Low Vision: Low vision is a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in low vision care can evaluate and prescribe optical devices and provide training and instruction to maximize the remaining usable vision for our Subscribers with low vision. After Preauthorization, covered low vision services (both In- and Out-of-Network) will include one comprehensive low vision evaluation every 5 years; high-power spectacles, magnifiers and telescopes; and follow-up care to include four visits in any five-year period. Network Providers will obtain the necessary Preauthorization for these services.

EXCLUSIONS

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

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

HOW YOUR PEDIATRIC VISION CARE BENEFITS WORK

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

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

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

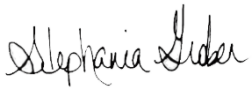
You may receive your eye examination and eyeglasses/contacts on different dates or through different Provider locations, if desired. However, complete eyeglasses must be obtained at one time, from one Provider. Continuity of care will best be maintained when all available services are obtained at one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

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

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

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

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



President of Blue Cross and Blue Shield of Oklahoma

BlueCross BlueShield of Oklahoma

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

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

The basic protections provided by the Association are:

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

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

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

To learn more about the above protections, please visit the Association's website at www.oklifega.org, or contact:

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

Oklahoma Department of Insurance
400 NE 50th Street
Oklahoma City, OK 73105
1-800-522-0071 or (405) 521-2828

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

BlueCross BlueShield of Oklahoma

Non-Discrimination Notice

Health Care Coverage Is Important For Everyone

We do not discriminate on the basis of race, color, national origin (including limited English knowledge and first language), age, disability, or sex (as understood in the applicable regulation). We provide people with disabilities with reasonable modifications and free communication aids to allow for effective communication with us. We also provide free language assistance services to people whose first language is not English.

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

If you believe we have failed to provide a service, or think we have discriminated in another way, you can file a grievance with:

Office of Civil Rights Coordinator	Phone:	855-664-7270 (voicemail)
Attn: Office of Civil Rights Coordinator	TTY/TDD:	855-661-6965
300 E. Randolph St., 35th Floor	Fax:	855-661-6960
Chicago, IL 60601	Email:	civilrightscoordinator@bcbsil.com

You can file a grievance by mail, fax or email. If you need help filing a grievance, please call the toll-free phone number listed on the back of your ID card (TTY: 711).

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

US Dept of Health & Human Services	Phone:	800-368-1019
200 Independence Avenue SW	TTY/TDD:	800-537-7697
Room 509F, HHH Building	Complaint Portal:	
Washington, DC 20201	ocrportal.hhs.gov/ocr/smartscreen/main.jsf	
	Complaint Forms:	
	hhs.gov/civil-rights/filing-a-complaint/index.html	

This notice is available on our website at bcbsok.com/legal-and-privacy/non-discrimination-notice

ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 855-710-6984 (TTY: 711) or speak to your provider.

Español Spanish	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 855-710-6984 (TTY: 711) o hable con su proveedor.
العربية Arabic	تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 855-710-6984 (TTY: 711) أو تحدث إلى مقدم الخدمة.

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

BlueCross BlueShield of Oklahoma

中文 Chinese	注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 855-710-6984（文本电话：711）或咨询您的服务提供商。
Français French	ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 855-710-6984 (TTY : 711) ou parlez à votre fournisseur.
Deutsch German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 855-710-6984 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.
ગુજરાતી Gujarati	ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 855-710-6984 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.
हिंदी Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 855-710-6984 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।
Italiano Italian	ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'855-710-6984 (tty: 711) o parla con il tuo fornitore.
한국어 Korean	주의: 한국어 를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 855-710-6984(TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.
Diné Navajo	SHOOH: Diné bee yáníłti'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hóló. Bee ahił hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'į' ahoot'i'ígíí éí t'áá jiik'eh hóló. Kohjį' 855-710-6984 (TTY: 711) hodíilnih doodago nika'análwo'í bich'į' hanidziih.
فارسي Farsi	توجه: اگر فارسي صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره 855-710-6984 (تله‌تایپ: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید.
Polski Polish	UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 855-710-6984 (TTY: 711) lub porozmawiaj ze swoim dostawcą.
РУССКИЙ Russian	ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 855-710-6984 (TTY: 711) или обратитесь к своему поставщику услуг.
Tagalog Tagalog	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 855-710-6984 (TTY: 711) o makipag-usap sa iyong provider.
اردو Urdu	توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔855-710-6984 (711:TTY) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔
Việt Vietnamese	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 855-710-6984 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.

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Extraterritorial Rider Supplement for Your Benefit Booklet

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Extraterritorial Rider
Supplement to Your Benefit Booklet

Introduction

This is a Supplement to your Benefit Booklet. If you permanently reside in one of the states specified in the Table of Contents, please read this carefully.

While this contract is issued in Oklahoma, the laws in some states require BCBSOK to provide certain specified benefits or apply differential handling for claims to permanent residents of that state who are members on this contract. This supplement includes Riders that describe how the coverage for permanent residents in these states differ from those residing in Oklahoma. If you are a permanent resident of one of the states in the Table of Contents, the benefits described in the Rider for that state apply to you.

In the event of a conflict between the Benefit Booklet and the Rider for the state in which you permanently reside, the provisions resulting in greater benefits will be in effect. Except as amended by the Rider, all terms, conditions, limitations, and exclusions of the Benefit Booklet to which the Rider apply and is hereby attached will remain in full force and effect.

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RIDER FOR RESIDENTS OF THE STATE OF CALIFORNIA

If you are a resident of the state of California, the Benefit Booklet, to which this Rider is attached and made a part, is amended as stated below to conform to the requirements of the state of California. In the event of a conflict between the Benefit Booklet and this Rider, the provisions resulting in the greater **benefits** will be in effect.

"Benefit Booklet" means "Benefit Booklet", "Certificate", "Member Handbook", or "Member Guide" issued to you under the group policy or group contract.

The term "**participant"** used in this Rider also means "covered person", "insured person", "insured member", "subscriber", or your "dependent" as may be defined in your Benefit Booklet.

"Group contract" used in this Rider means "group policy or group contract".

"Group contractholder" used in this Rider means "group policyholder or group contractholder".

"You" or "your" used in this Rider means the insured **employee** or insured member of the contractholder who is covered under the group contract.

The section titles listed below are either the same section titles indicated in your Benefit Booklet, or other titled sections in your Benefit Booklet describing the same or similar **benefits** and provisions. **Benefits** will be payable for **covered services** indicated in this Rider in accordance with the corresponding section title indicated in your Benefit Booklet.

Terms that are in bold print are terms that are defined in your Benefit Booklet or this Rider.

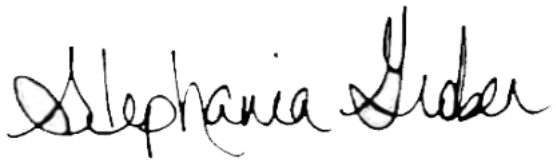
1. The ***WHO GETS BENEFITS*** section, ***ELIGIBILITY, ENROLLMENT, CHANGES & TERMINATION*** section, or a similar section in your Benefit Booklet describing who is eligible to receive **benefits**, is amended to include the following:

   a. Domestic Partner Coverage
   Coverage for a registered domestic partner of a **participant** will be provided on the same basis as coverage for a spouse of a **participant**. We cannot discriminate in coverage between spouses or domestic partners of a different sex or of the same sex.

Except as amended by this Rider, all terms, conditions, limitations, and exclusions of the Benefit Booklet to which this Rider is attached will remain in full force and effect.

Effective Date of Rider: January 1, 2026, or the date on which your coverage begins under the group contract, whichever is later.

Blue Cross and Blue Shield of Oklahoma



Stephania Grober
President,
Blue Cross and Blue Shield of Oklahoma

BlueCross BlueShield
of Oklahoma

RIDER FOR RESIDENTS OF THE STATE OF KANSAS

If you are a resident of the state of Kansas, the Benefit Booklet, to which this Rider is attached and made a part, is amended as stated below to conform to the requirements of the state of Kansas. In the event of a conflict between the Benefit Booklet and this Rider, the provisions resulting in the greater **benefits** will be in effect.

"Benefit Booklet" means "Benefit Booklet", "Certificate", "Member Handbook", or "Member Guide" issued to you under the group policy or group contract.

The term "**participant"** used in this Rider also means "covered person", "insured person", "insured member", "subscriber", or your "dependent" as may be defined in your Benefit Booklet.

"Group contract" used in this Rider means "group policy or group contract".

"Group contractholder" used in this Rider means "group policyholder or group contractholder".

"You" or "your" used in this Rider means the insured **employee** or insured member of the contractholder who is covered under the group contract.

The section titles listed below are either the same section titles indicated in your Benefit Booklet, or other titled sections in your Benefit Booklet describing the same or similar **benefits** and provisions. **Benefits** will be payable for **covered services** indicated in this Rider in accordance with the corresponding section title indicated in your Benefit Booklet.

Terms that are in bold print are terms that are defined in your Benefit Booklet or this Rider.

1. The ***WHO GETS BENEFITS*** section, ***ELIGIBILITY, ENROLLMENT, CHANGES & TERMINATION*** section, or a similar section in your Benefit Booklet describing who is eligible to receive **benefits**, is amended to include the following:

   a. Open Enrollment
   No **participant** will be excluded from eligibility or coverage under the group contract, except when either:
   - You choose to not be covered by the group contract
   - You or a **dependent** enroll after the open enrollment opportunity has closed

An open enrollment opportunity is the period beginning on the date of your initial eligibility and ends thirty-one (31) days after the initial eligibility date.

b. Newborn Infant and Adopted Child

Coverage for your newly born **child** will become effective upon the moment of birth**.**

Coverage for your adopted **child** will become effective upon one (1) of the following**:**

- The moment of birth, if a petition for adoption was filed within thirty-one (31) days after the birth of the **child**
- The date the petition for adoption was filed
- The certified date of placement if the **child** is placed in your home by a child placement agency for the purpose of adoption

It is required that in no case will the time from the date of placement to the date the petition for adoption is filed, exceed 280 days.

Coverage will continue beyond the initial thirty-one (31) day period if you take the following actions within the initial thirty-one (31) day period:

- Notify us about one (1) of the following:
  - The birth of your **child**
  - The filing of the petition for adoption
  - The certification that a **child** has been placed in your home for adoption
- Pay any required premiums for the **child**

2. The ***COVERED SERVICES*** section, ***COMPREHENSIVE HEALTH CARE SERVICES*** section, ***HOW BLUELINCS WORKS – TYPES OF COVERED CARE*** section, ***SPECIAL BENEFIT PROVISIONS*** section, or a similar section in your Benefit Booklet describing your covered **benefits**, is amended to include the following **benefits**:

a. Breast Reconstruction

Covered services include **medically necessary** reconstructive surgery following a mastectomy in the manner determined by the attending physician and the patient to be appropriate. These services include:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery on the other breast to make it symmetrical with the reconstructed breast
- Prostheses
- Treatment of physical complications at all stages of the mastectomy, including lymphedemas

b. Dental Care – General Anesthesia and Medical Care Facility

Covered services will include the administration of **medically necessary** general anesthesia and **medical care facility** costs for dental care provided to any of the following:

- A **child** five (5) years old or younger
- A **participant** who is severely disabled

- A **participant** who has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided

Covered services do not include any dental procedures.

Medical care facility means a **hospital**, ambulatory surgical center, or recuperation center.

c. Inpatient Stay for Post-Maternity Care

Covered services include inpatient care for a mother and her newborn **child** in a medical care facility as follows:

- A minimum of forty-eight (48) hours of inpatient care following a vaginal delivery
- A minimum of ninety-six (96) hours of inpatient care following a cesarean delivery

Any decision to shorten the length of inpatient stay to less than that provided will be made by the **attending physician**.

If the newly born **child** is delivered in the home, coverage of inpatient care is not required unless determined to be **medically necessary** by the **attending physician.**

Attending physician means the person licensed to practice medicine and surgery who is responsible for the care provided to the mother or newborn.

d. Newborn Infant

Covered services include:

- Necessary care and treatment of medically diagnosed congenital defects and birth abnormalities
- Routine and necessary immunizations for all newly born **children** from birth to six (6) years of age which will include:
    - Five (5) doses of vaccine against diphtheria, pertussis, tetanus
    - Four (4) doses of vaccine against polio and Haemophilus B (Hib)
    - Three (3) doses of vaccine against Hepatitis B
    - Two (2) doses of vaccine against measles, mumps, and rubella
    - One (1) dose of vaccine against varicella
    - Other vaccines and dosages as may be prescribed by the Secretary of Health and Environment

These immunizations will not be subject to any **deductibles, copayments**, or **coinsurance**.

e. Osteoporosis

Covered services include the diagnosis, treatment, and management of osteoporosis provided by a person licensed to practice medicine and surgery in Kansas, for participants with a condition or medical history for which bone mass measurement is **medically necessary**.

f. Services Provided by a Psychologist
Services within the scope of a licensed psychologist will be covered when performed by either a licensed psychologist or **physician**.

g. Services Provided by a Specialist Social Worker
Services within the scope of a licensed specialist social worker authorized to engage in private, independent practice will be covered when performed by either a licensed specialist social worker or **physician**.

h. Treatment of Mental Conditions and Substance Abuse
Covered services include treatment for the following:

- Mental illness in a licensed medical care facility
- Alcoholism, drug abuse, or substance use disorders in any of the following licensed facilities:
    - A treatment facility for alcoholics
    - A treatment facility for drug abusers
    - A community mental health center or clinic
    - A psychiatric **hospital**

Coverage does not include:

- Any assessment required by a diversion agreement or by order of a court to attend a certified alcohol and drug safety action program
- Evaluations and diagnostic tests ordered or requested in connection with
    - Criminal actions
    - Divorce
    - Child custody or child visitation proceedings

3. The ***PHARMACY BENEFITS*** section, ***PRESCRIPTION DRUG PROGRAM BENEFITS*** *section,* ***OUTPATIENT PRESCRIPTION DRUGS AND RELATED SERVICES*** section, or similar section in your Benefit Booklet describing your prescription drug **benefits**, is amended to include the following **benefits**:

a. Mental Illness Prescription Drugs
Covered drugs include psycho-therapeutic drugs prescribed for the treatment of mental illness. Coverage will be no less favorable than the coverage for other prescription drugs.

b. Off-Label Cancer Prescription Drugs
Covered drugs include Food and Drug Administration (FDA) approved drugs to be used in cancer treatment, even if the drug has not been approved by the FDA for that particular treatment. The drugs must be recognized for cancer treatment in either of the following:

- A substantially accepted peer-reviewed medical literature
- A nationally recognized compendium

The prescribing **physician** shall submit to us documentation supporting the proposed off-label use or uses if requested.

The following are not covered services:

- Any drug when the FDA has determined the drug's use to be contraindicated
- An experimental drug not approved for any indication by the FDA

Peer-reviewed medical literature means a published scientific study in a journal or other publication in which original manuscripts have been published only after having been critically reviewed for scientific accuracy, validity and reliability by unbiased independent experts, and that has been determined by the International Committee of Medical Journal Editors to have met the uniform requirements for manuscripts submitted to biomedical journals. **Peer-reviewed medical literature** does not include publications or supplements to publications that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier.

c. Orally Administered Anticancer Medications
Covered drugs include prescribed orally administered anticancer medication used to kill or slow the growth of cancerous cells. These drugs will be provided on a basis no less favorable than injected or intravenously administered cancer medications.

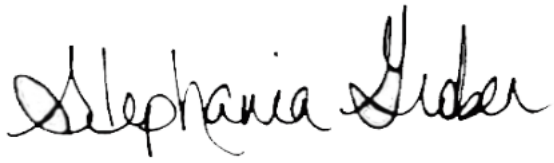
4. The ***GENERAL PROVISIONS*** section or ***OTHER COVERAGE AND RIGHT OF RECOUPMENT*** section, or similarly named section in your Benefit Booklet is amended to include the following:

a. Subrogation Prohibition
If your Benefit Booklet includes a provision about subrogation, it is no longer applicable to your group contract.

Except as amended by this Rider, all terms, conditions, limitations, and exclusions of the Benefit Booklet to which this Rider is attached will remain in full force and effect.

Effective Date of Rider: January 1, 2026, or the date on which your coverage begins under the group contract, whichever is later.

Blue Cross and Blue Shield of Oklahoma



Stephania Grober
President,
Blue Cross and Blue Shield of Oklahoma

BlueCross BlueShield
of Oklahoma

RIDER FOR RESIDENTS OF THE STATE OF MARYLAND

If you are a resident of the state of Maryland, the Benefit Booklet, to which this Rider is attached and made a part, is amended as stated below to conform to the requirements of the state of Maryland. In the event of a conflict between the Benefit Booklet and this Rider, the provisions resulting in the greater **benefits** will be in effect.

"Benefit Booklet" means "Benefit Booklet", "Certificate", "Member Handbook", or "Member Guide" issued to you under the group policy or group contract.

The term "**participant"** used in this Rider also means "covered person", "insured person", "insured member", "subscriber", or your "dependent" as may be defined in your Benefit Booklet.

"Group contract" used in this Rider means "group policy or group contract".

"Group contractholder" used in this Rider means "group policyholder or group contractholder".

"You" or "your" used in this Rider means the insured **employee** or insured member of the contractholder who is covered under the group contract.

The section titles listed below are either the same section titles indicated in your Benefit Booklet, or other titled sections in your Benefit Booklet describing the same or similar **benefits** and provisions. **Benefits** will be payable for **covered services** indicated in this Rider in accordance with the corresponding section title indicated in your Benefit Booklet.

Terms that are in bold print are terms that are defined in your Benefit Booklet or this Rider.

1. The ***COVERED SERVICES*** section, ***COMPREHENSIVE HEALTH CARE SERVICES*** section, ***HOW BLUELINCS WORKS – TYPES OF COVERED CARE*** section, ***SPECIAL BENEFIT PROVISIONS*** section, or a similar section in your Benefit Booklet describing your covered benefits, is amended to include the following benefits:

   a. Licensed Professional Counselor Services
   Covered services will include medically necessary services performed in an appropriate setting and manner that fall within the lawful scope of practice of any of the following licensed providers:
   - A clinical professional counselor
   - A clinical marriage and family therapist
   - A clinical alcohol and drug counselor
   - A clinical professional art therapist

b. Nurse Anesthetist Services

Covered services for a **nurse anesthetist** will be provided regardless of whether the services are performed by a **physician** or a **nurse anesthetist**. Coverage will not be subject to the **nurse anesthetist** being employed by a **physician**.

A **nurse anesthetist** means a registered nurse who is certified as a **nurse anesthetist** by either:

- The Council on Certification of Nurse Anesthetists
- The Council on Recertification of Nurse Anesthetists

c. Nurse Midwife Services

Medically necessary services performed in an appropriate setting and manner and provided within the legal scope of practice of a **nurse midwife** will be covered regardless of whether the service is provided by a **physician** or a **nurse midwife**.

Coverage will not be subject to the **nurse midwife** being employed by a **physician** or acting under a **physician's** orders.

A **nurse midwife** means a licensed registered nurse who is certified as a **nurse midwife** by the American College of Nurse-Midwives.

d. Optometrist Services

Medically necessary services performed in an appropriate setting and manner and provided within the legal scope of practice of an optometrist will be covered if the optometrist is licensed under the Health Occupations Article.

e. Health Care Provider

Medically necessary services performed in an appropriate setting and manner and provided within the legal scope of practice of a health care **provider** licensed under the Health Occupations Article will be covered. These providers include:

- A clinical alcohol and drug counselor
- A clinical marriage and family therapist
- A clinical professional art therapist
- A clinical professional counselor
- A graduate alcohol and drug counselor
- A graduate marriage and family therapist
- A graduate professional art therapist
- A graduate professional counselor

f. Psychologist Services

Medically necessary services performed in an appropriate setting and manner and provided within the legal scope of practice of a licensed psychologist will be covered regardless of whether the service is provided by a physician or licensed psychologist.

g. Home Medical Equipment Coverage

Covered services include **medically necessary** home medical equipment. We will pay the **provider** directly for home medical equipment if the **participant** has an executed assignment of **benefits** with a **provider**. The **provider** will not receive a lower payment than the amount agreed upon, subject to the **copayment** and **deductible** amounts.

We are required to notify both the **provider** and **participant** before authorization is terminated.

Home medical equipment and services may be purchased with our and the **provider's** consent if both:

- The purchase or rental prices of the equipment are disclosed to us before the initial election to rent the equipment or on our receipt of the initial claim from the **provider**
- The attending **physician** certifies there is no change in the medical condition of the **participant**

h. House Confinement: Treatment Elsewhere

Covered services for a **participant** confined to home due to disability or sickness will be extended if the individual leaves home for medical treatment. The services will be covered regardless of the place of medical treatment.

i. Treatment in Public Hospitals or Institutions

Covered services for the treatment of tuberculosis, mental illness, or another illness received in a **hospital** or other institution of the state or of a county or municipal corporation of the state, will be covered whether or not the **hospital** or other institution is deemed charitable.

2. The ***GENERAL PROVISIONS*** section or ***OTHER COVERAGE AND RIGHT OF RECOUPMENT*** section, or similarly named section in your Benefit Booklet is amended to include the following:

a. Conversion of Group Health Insurance Policy

If you are covered under a group contract that includes disability benefits and your membership terminates for any reason other than failure to pay a required premium or contribution, you are entitled, without evidence of insurability, to an individual disability income insurance policy issued by a Maryland licensed issuer which offers such coverage. Where we do not offer such coverage in Maryland, information on how to access such coverage from an alternative issuer will be provided to you.

A policy issued under this section will be eligible to take effect immediately after the termination of coverage under the group contract if the **participant** does both of the following:

- Makes a timely written request for an individual policy
- Pays the first premium for the individual policy

This policy will be guaranteed renewable for the term or to the limiting age for which **benefits** would have been provided.

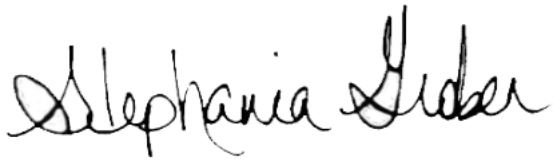
You will be provided the option to enroll in coverage where the level of benefits under an individual policy issued under this section will equal approximately the disability benefits that would have been provided if coverage under the group contract had not terminated.

We may limit the right of conversion to participants who were previously covered under the group contract for at least one (1) year.

Except as amended by this Rider, all terms, conditions, limitations, and exclusions of the Benefit Booklet to which this Rider is attached will remain in full force and effect.

Effective Date of Rider: January 1, 2025, or the date on which your coverage begins under the group contract, whichever is later.

Blue Cross and Blue Shield of Oklahoma



Stephania Grober
President,
Blue Cross and Blue Shield of Oklahoma

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of Oklahoma

RIDER FOR RESIDENTS OF THE STATE OF MISSISSIPPI

If you are a resident of the state of Mississippi, the Benefit Booklet, to which this Rider is attached and made a part, is amended as stated below to conform to the requirements of the state of Mississippi. In the event of a conflict between the Benefit Booklet and this Rider, the provisions resulting in the greater **benefits** will be in effect.

"Benefit Booklet" means "Benefit Booklet", "Certificate", "Member Handbook", or "Member Guide" issued to you under the group policy or group contract.

The term "**participant"** used in this Rider also means "covered person", "insured person", "insured member", "subscriber", or your "dependent" as may be defined in your Benefit Booklet.

"Group contract" used in this Rider means "group policy or group contract".

"Group contractholder" used in this Rider means "group policyholder or group contractholder".

"You" or "your" used in this Rider means the insured **employee** or insured member of the contractholder who is covered under the group contract.

The section titles listed below are either the same section titles indicated in your Benefit Booklet, or other titled sections in your Benefit Booklet describing the same or similar **benefits** and provisions. **Benefits** will be payable for **covered services** indicated in this Rider in accordance with the corresponding section title indicated in your Benefit Booklet.

Terms that are in bold print are terms that are defined in your Benefit Booklet or this Rider.

1. The ***COVERED SERVICES*** section, ***COMPREHENSIVE HEALTH CARE SERVICES*** section, ***HOW BLUELINCS WORKS – TYPES OF COVERED CARE*** section, ***SPECIAL BENEFIT PROVISIONS*** section, or a similar section in your Benefit Booklet describing your covered **benefits**, is amended to include the following **benefit**:

   a. Temporomandibular Joint Disorder and Craniomandibular Disorder Coverage
   Coverage for diagnostic and surgical treatment of temporomandibular joint disorder and craniomandibular disorder will be the same as that for treatment to any other joint in the body. Coverage applies to treatment administered or prescribed by a **physician** or dentist.

2. If your group contract covers prescription drugs, the ***PHARMACY BENEFITS*** section, ***PRESCRIPTION DRUG BENEFITS*** section, ***OUTPATIENT PRESCRIPTION DRUGS AND RELATED SERVICES*** section, or similar section in your Benefit Booklet describing your prescription drug **benefits**, is amended to include the following **benefit**:

   a. Prescription Drug Program Cash Discount Cards Prohibition
   We will not issue or distribute any **cash discount card** that participating pharmacies must accept or honor as a condition or requirement of participation in the **prescription drug program**. Participating pharmacies that honor or accept prescription drug program identification cards will only honor or accept these discounts if we pay a portion of the cost of the discount given by the **pharmacy** for prescriptions purchased with the use of the **cash discount card**

   Prescription drug program means a program or plan that provides coverages and benefits for prescription drugs for members or participants in the program, whether the program is a separate program or part of a health benefit plan.

   Cash discount card means a card, other than the program identification card of a member or participant of a prescription drug program, that allows the holder to obtain a discount on a prescription drug when paying for the prescription at the point-of-sale

3. The ***GENERAL PROVISIONS*** section or ***OTHER COVERAGE AND RIGHT OF RECOUPMENT*** section, or similarly named section in your Benefit Booklet is amended to include the following

   a. Continuation Privilege
   If you are covered under the group contract and your employment or membership terminates, you may continue your coverage for yourself and eligible **dependents**. Continuation will be available for a **participant** who has been continuously insured under the group contract, or for similar **benefits** under any other group contract that it replaced, during the period of three (3) consecutive months immediately before the date of termination. The continued policy must cover all dependents covered under the group contract.

   A **dependent** spouse may elect continuation of dependent spouse and dependent child coverage for a period not to exceed twelve (12) months after:
   - The date of death of the employee or member
   - The date of the spouse's divorce from the employee or member
   - The date that the employee or member becomes entitled to Medicare benefits

   A **dependent child** of an employee or member may elect continuation of coverage for a period not to exceed twelve (12) months after the **child** ceases to be an eligible **dependent**.

   Continuation will not be available to any **participant** if:
   - The **participant** is eligible for other coverage within thirty-one (31) days of the date of termination
   - The coverage was terminated due to fraud or non-payment

- The **participant** is eligible for continuation under COBRA
- The **participant** is entitled to **benefits** under Medicare.

Continuation will not include dental, vision care or any other **benefits** provided under the group policy in addition to its **hospital**, surgical or major medical **benefits**.

A **participant** choosing continuation must submit a written election form and meet the following requirements:

- Payment of the full group rate due in advance. This rate cannot exceed the standard group rate applicable to the **participant** under the group contract
- Payment of the first contribution on or before the date on which the **participant's** insurance would otherwise terminate
- Payment of premiums at least monthly

b. Additional Continuation for Certain Dependents

We will also provide notice of continuation privilege to certain eligible **dependents** within fourteen (14) days of any of the following:

- the notification by the **participant** of the ineligibility of a **dependent child**
- the notification by the **participant** or spouse of their divorce
- the death of the **participant**

Eligible individuals have thirty (30) days after the notice to elect continuation of coverage.

c. Continuation Privilege Termination

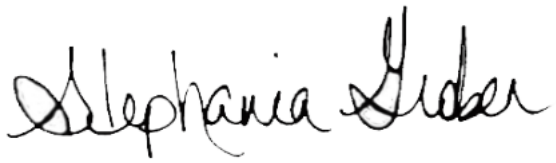
Continuation of coverage for any **participant** will terminate on the earliest of the following dates:

- The date twelve (12) months after the date the **participant's** insurance under the policy would otherwise have terminated because of termination of employment or membership.
- The date ending the period for which the **participant** last makes their required contribution, if they discontinue their contributions.
- The date the **participant** becomes or is eligible for similar benefits under any arrangement of coverage for individuals in a group, whether insured or uninsured.
- The date on which the group contract is terminated or, in the case of a multiple employer plan, the date the contractholder terminates participation under the group master policy.
- The date a surviving spouse or former spouse of the participant remarries and becomes covered under a group health plan that does not exclude coverage for preexisting conditions.
- The date the **participant** becomes entitled to benefits under Medicare.

Except as amended by this Rider, all terms, conditions, limitations, and exclusions of the Benefit Booklet to which this Rider is attached will remain in full force and effect.

Effective Date of Rider: January 1, 2026, or the date on which your coverage begins under the group contract, whichever is later.

Blue Cross and Blue Shield of Oklahoma



Stephania Grober,
President,
Blue Cross and Blue Shield of Oklahoma

BlueCross BlueShield
of Oklahoma

RIDER FOR RESIDENTS OF THE STATE OF SOUTH CAROLINA

If you are a resident of the state of South Carolina, the Benefit Booklet, to which this Rider is attached and made a part, is amended as stated below to conform to the requirements of the state of South Carolina. In the event of a conflict between the Benefit Booklet and this Rider, the provisions resulting in the greater **benefits** will be in effect.

"Benefit Booklet" means "Benefit Booklet", "Certificate", "Member Handbook", or "Member Guide" issued to you under the group policy or group contract.

The term "**participant"** used in this Rider also means "covered person", "insured person", "insured member", "subscriber", or your "dependent" as may be defined in your Benefit Booklet.

"Group contract" used in this Rider means "group policy or group contract".

"Group contractholder" used in this Rider means "group policyholder or group contractholder".

"You" or "your" used in this Rider means the insured **employee** or insured member of the contractholder who is covered under the group contract.

The section titles listed below are either the same section titles indicated in your Benefit Booklet, or other titled sections in your Benefit Booklet describing the same or similar **benefits** and provisions. **Benefits** will be payable for **covered services** indicated in this Rider in accordance with the corresponding section title indicated in your Benefit Booklet.

Terms that are in bold print are terms that are defined in your Benefit Booklet or this Rider.

1. The ***WHO GETS BENEFITS*** section, ***ELIGIBILITY, ENROLLMENT, CHANGES & TERMINATION*** section, or a similar section in your Benefit Booklet describing who is eligible to receive **benefits**, is amended to include the following:

   a. Continued Coverage of Dependent Children
   Coverage for your unmarried **dependent child** may continue under the group contract beyond the age of twenty-six (26) if your **dependent child** is:
   - Incapable of self-sustaining employment by reason of intellectual disability or physical disability, and
   - Chiefly dependent upon you for support and maintenance

Proof of such incapacity and dependency must be provided within thirty-one (31) days of the **child's** attainment of the limiting age. After the two-year period following your **child's** attainment of the limiting age, we may require proof satisfactory to us, of the continuance of such incapacity and dependency but no more frequently than annually.

b. Medically Necessary Leave of Absence for Dependent Children

A **dependent child** undergoing a **medically necessary leave of absence** from a postsecondary educational institution **is entitled to the same benefits** during this approved absence.

Any **medically necessary leave of absence** for a **dependent child** requires written certification by a treating **physician** of the **dependent child** stating the **child** is suffering from a serious illness or injury and that the leave of absence or other change of enrollment is **medically necessary**.

In the case of a **dependent child** we will not terminate coverage of the **child** due to a medically **necessary leave** of absence before the date that is the earlier of either:

- One year after the first day of the **medically necessary leave of absence**
- The date on which the coverage would otherwise terminate under the terms of the group contract

Medically necessary leave of absence means a leave of absence of a **dependent child** from a postsecondary educational institution, including an institution of higher education as defined in Section 102 of the Higher Education Act of 1965, or any other change in enrollment of the **child** at such an institution. Any leave of absence must:

- Commence while the **child** is suffering from a serious illness or injury
- Be **medically necessary**
- Cause the **child** to lose student status for purposes of coverage under the terms of the group contract

c) Eligibility to Enroll

We may not establish rules for eligibility based on any of the following health status- related factors in relation to the individual or a **dependent** of the individual:

- Health status
- Medical condition, including physical and mental illnesses
- Claims experience
- Receipt of health care
- Medical history
- Genetic information
- Evidence of insurability (including conditions arising out of acts of domestic violence)
- Disability

As a condition of enrollment or continued enrollment under the group contract, no individual or **dependent** enrolled is required to pay a premium or contribution greater than the premium or contribution for a similarly situated **participant** on the basis of any health status-related factor.

2. The ***COVERED SERVICES*** section, ***COMPREHENSIVE HEALTH CARE SERVICES*** section, ***HOW BLUELINCS WORKS – TYPES OF COVERED CARE*** section, ***SPECIAL BENEFIT PROVISIONS*** section, or a similar section in your Benefit Booklet describing your covered **benefits**, is amended to include the following **benefits**:

   a. Mental Health Benefits
   If your group contract does not include an annual limit on medical and surgical **benefits**, we may not impose any annual limit on mental health or substance use disorder **benefits**.

   If your group contract provides coverage for medical or surgical **benefits** provided by **out-of-network providers**, we will provide coverage for mental health or substance use disorder **benefits** provided by **out-of-network providers**.

3. The ***CLAIM FILING AND APPEALS PROCEDURES*** section, ***CLAIMS FILING PROCEDURES*** section, ***COMPLAINT/APPEAL PROCEDURE*** section, ***METHODS OF PAYMENT AND CLAIM FILING*** section, ***MEMBER COMPLAINTS AND APPEALS*** section, or similar section in your Benefit Booklet describing claims and appeals, is amended to include the following:

   a. Notice of Claim
   Written notice of claim must be given to us within twenty (20) days after the occurrence or start of the loss on which the claim is based. If notice is not given in that time, the claim will remain valid if it can be shown that notice was not possible and that notice was given as soon as reasonably possible.

   b. Claim Forms
   Upon receipt of your notice of claim, we will provide you or the contractholder with claim forms for filing proof of loss. If the claim forms are not provided within fifteen (15) days after we receive the notice of claim, the person making the claim is considered to have complied with the requirements of the group contract as to proof of loss if they have submitted written proof covering the occurrence, character, and extent of the loss within the time stated in the Proof of Loss provision.

   c. Proof of Loss
   Written proof of loss of time for disability must be provided to us within ninety (90) days after the start of the period for which we are liable. Future written proofs of the continuance of the disability must be provided to us upon request. Written proof of any other loss must be provided to us within ninety (90) days after the date of loss. Failure to provide proof within the time required will not cause a claim to be invalidated or reduced if it was not reasonably possible to provide such proof and it was provided as soon as reasonably possible. Proof must be submitted no later than one (1) year from the time proof is otherwise required unless you are legally incapacitated.

d. Time of Payment of Claims
Benefits payable will be paid no more than sixty (60) days after the receipt of proof of loss.

4. The ***GENERAL PROVISIONS*** section, ***OTHER COVERAGE AND RIGHT OF RECOUPMENT*** section, or similarly named section in your Benefit Booklet is amended to include the following:

a. Grounds for nonrenewal or discontinuation of coverage
Cancellation or discontinuance of coverage can only occur in the event of one or more of the following:

- Your contractholder has failed to pay premiums or contributions in accordance with the terms of the coverage
- We have not received timely premium payments
- Your contractholder has performed an act of fraud or made an intentional misrepresentation of fact under the terms of the coverage
- You, or an individual acting as your representative, has fraudulently or intentionally misrepresented a person's prior health condition. In this instance, we reserve the right to deny coverage or to impose as a condition of continued coverage the exclusion of the condition misrepresented
- Your contractholder has failed to comply with participation or contribution rules
- We cease to offer coverage in the market
- There are no longer any enrollees living, residing or working within the **service area**

b. Discontinuation of Coverage
If we decide in any case to discontinue offering all health insurance coverage we must do both of the following:

- Notify the Director of Insurance, the contractholder and all **participants** at least one hundred and eighty (180) days before the date of discontinuation
- Discontinue all coverage and renewals issued in the state

c. Grace Period
The contractholder is entitled to a grace period of thirty-one (31) days for each premium payment after the first premium. Coverage will remain in force during the grace period unless the contractholder has provided us with a written notice requesting termination of coverage in advance of the date of termination in accordance with the terms of the group contract. The contractholder is liable for the payment of a pro rata premium for the time the group contract was in force during the grace period. Any valid claims for covered losses received prior to the end of the grace period will be covered.

d. Incontestability

Except for fraudulent misstatements made by a person covered under your group contract:

- The validity of your group contract may not be contested after it has been in force for two (2) years after its date of issue
- No statement made by any **participant** under the group contract relating to insurability may be used in contesting the validity of coverage:
    - After the coverage has been in force for two (2) years before the questioning of the coverage
    - Unless the statement is provided in writing signed by the participant making the statement

e. Legal Action

No legal action may be brought to recover under the group contract within sixty (60) days after written proof of loss has been filed as required and no such action may be brought at all unless brought within six (6) years from the time proof of loss is required to be provided.

f. Continuation Privilege

Any **participant** continuously covered for at least six (6) months whose coverage has been terminated for any reason other than nonpayment of premiums, is entitled to continuation of coverage for the remainder of the month in which they are terminated plus an additional six (6) months. Continuation of coverage is subject to the group contract, or a successor policy remaining in force and the **participant** paying the entire premium, including any portion usually paid by the former **employer**, before the date each month that the group policy month begins.

If a **participant** is covered under a right of continuation but also covered under another health care plan, that other health care plan will be primary. Benefits paid under the continuation privilege will be secondary.

A **participant** is not entitled to continuation of coverage if:

- Eligible for other group coverage which provides similar **benefits**
- Eligible for Medicare **benefits**

Except as amended by this Rider, all terms, conditions, limitations, and exclusions of the Benefit Booklet to which this Rider is attached will remain in full force and effect.

Effective Date of Rider: January 1, 2025, or the date on which your coverage begins under the group contract, whichever is later.

Blue Cross and Blue Shield of Oklahoma

Stephania Grober
President,
Blue Cross and Blue Shield of Oklahoma

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