BlueCross BlueShield of Oklahoma

To Use or Disclose Protected Health Information (PHI)

Standard Authorization Form

I. Individual (Name and information of person whose protected health information is being disclosed):

Name			Date of Birth
Group #	Identification/Subscriber #		Social Security Number
Address	City	State	ZIP
Area Code & Telephone Number			

II. Authorization and Purpose:

I request and authorize Blue Cross and Blue Shield of Oklahoma to disclose my protected health information as described below. **I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.**

Persons/Organizations authorized to receive your information		Relationship	Purpose
Address	City	State	ZIP

III. Specific Description of Information to be Used or Disclosed

(Please complete Parts A and B in this Section) **This Authorization CANNOT be used to disclose Psychotherapy Notes.**

A. Release of *Sensitive* Protected Health Information Under State Law

You *must* check "yes" or "no" if you authorize the release of medical information, test results, records or communications specific to
(note: "yes" means this information is included in the categories you designate in Part B below):

- Human Immunodeficiency Virus (HIV) or HIV/Acquired Immune Deficiency Syndrome;
- Sexually transmitted or communicable diseases (includes hepatitis, as well as venereal diseases);
- Drug, alcohol or substance abuse;
- Mental health or developmental disabilities (including mental retardation or similar disabilities, for example, those attributable to cerebral palsy, autism or neurological dysfunctions); and
- Genetic testing.

Yes ☐

No ☐

B. Release of Protected Health Information *(check one or more)*

		Dates of Services From:	To:
☐ **Health Plan Benefit Information**	Includes information contained in your benefit booklet (i.e., copayments, coinsurance, eligibility and other benefit information).	_____	_____
☐ **Claims**	Includes information related to payment of your claims for service you received, including pertinent information located on a claim form (i.e., billed amount, general procedure descriptions, claim payment or denial reasons, etc.).	_____	_____
☐ **Service Determination Information**	Includes any information related to pre-service, concurrent and post-service decisions.	_____	_____
☐ **Premium**	Includes information related to billing cycles, bank draft changes, etc.	_____	_____
☐ **Services from (provider or supplier)**	Provider name: _____ (Includes information related to services rendered by a specific provider or supplier.)	_____	_____
☐ **Other**	_____ (Specify other information that is not listed in one of the categories above.)	_____	_____

IV. Expiration and Revocation

Expiration: This authorization will expire on (must choose one):

☐ **One year from the date it is signed** ☐ **Other (insert date or event):** _____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice to the address listed at the bottom of this form. **I understand that revocation of this authorization will not affect any action the above named entity took in reliance on this authorization before the above named entity received my written notice of revocation.**

V. Signature (this document must be signed by the individual, parent of minor child or the individual's personal representative):

I understand that this authorization is voluntary and that the health plan cannot condition my eligibility for benefits, treatment, enrollment or payment of claims on the signing of this authorization. I understand that if I am signing on behalf of a minor child, this authorization will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

_____ _____

Signature **Date: month/day/year**

If you are signing as a Power of Attorney, Legal Guardian, Executor or Administrator, complete the following and attach a copy of the Legal documents. You do NOT have to attach copies of documents if they are already on file with Blue Cross and Blue Shield of Oklahoma.

_____ _____

Personal Representative's Name **Relationship to Individual**

_____ _____ _____ _____

Personal Representative's Address **City** **State** **ZIP**

_____

Personal Representative's Area Code & Telephone Number

BEFORE RETURNING YOU SHOULD KEEP A COPY FOR YOUR RECORDS BY EITHER:

1. MAKING A PHOTOCOPY OF THIS SIGNED AUTHORIZATION; OR
2. COMPLETING AND SIGNING THE DUPLICATE AUTHORIZATION FORM YOU RECEIVED OR PRINTED

Mail your completed signed authorization to:
Blue Cross and Blue Shield of Oklahoma
P.O. Box 3238
Naperville, IL 60566-7238

If you need assistance completing the form, please contact our Member Service Department at 1-866-520-2507.

Prescription Drug Claim Form

BlueCross BlueShield of Oklahoma

See instructions on reverse.

Patient Information

ID Number

Group Number –

Date of Birth / / ❑ Male ❑ Female

Patient Name (First, Last)

Street Address

City State ZIP

Patient's Relationship to Subscriber/Member:

❑ Self ❑ Spouse ❑ Dependent

I certify that the information is correct and that the patient indicated above is eligible for benefits. I have received the medications described herein and authorize release of all information contained on this claim form to Prime Therapeutics. I agree that any benefits payable hereunder for prescription drugs are not assignable and that any assignment thereof shall be void. I further represent that there has been no assignment of benefits hereunder.

I understand that Blue Cross and Blue Shield of Oklahoma use or disclosure of individually identifiable health information, whether furnished by me or obtained from other sources such as medical or pharmacy providers, shall be in accordance with the federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996). Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Patient/Subscriber/Member or Legal Representative Signature

Is this medication for an on-the-job-injury? . . . . . ❑ Yes ❑ No

Do you have other insurance for prescription medications? . . . . . ❑ Yes ❑ No

If yes, please provide Name of other Insurance: _____

Policy Number: _____

Please include any pharmacy receipts related to this claim with this form.

Subscriber/Member Information

Name (First, Last)

Pharmacy Information

Pharmacy Name

Pharmacy Address

City State ZIP

Prescription Claim Information

Original pharmacy receipts are required. Please attach receipts to space provided on the back of form. If receipts are not included, please have pharmacist complete and sign the bottom of this form.

Was this prescription medication purchased outside the U.S.A.? . . . . . ❑ Yes ❑ No

All fields below must be completed.
(Example on back of form.)
Call your pharmacist if you need assistance.

1 Rx Number

Date Filled / /

Quantity _____ Day Supply

Name of Medication _____

NDC Number

(Your pharmacist can provide the NDC number identifying the drug.)

NPI Number

Prescription Cost $.

Balance Due $.

2 Rx Number

Date Filled / /

Quantity _____ Day Supply

Name of Medication _____

NDC Number

(Your pharmacist can provide the NDC number identifying the drug.)

NPI Number

Prescription Cost $.

Balance Due $.

3 Rx Number

Date Filled / /

Quantity _____ Day Supply

Name of Medication _____

NDC Number

(Your pharmacist can provide the NDC number identifying the drug.)

NPI Number

Prescription Cost $.

Balance Due $.

X _____ _____

Signature of Pharmacist or Representative (Required only if original pharmacy receipts are not included.) Date

Pharmacy/Prescription Information

1. Use a **separate claim form** for each patient. All information provided on or attached to this claim form must be for the same patient.
2. Tape or glue pharmacy receipts in the spaces provided. When you tape or glue your receipts, it is not necessary for the receipts to fit exactly within the spaces provided. If the taped or glued receipts overlap each other, be sure that all information on each receipt is readable. Each receipt must show:
   - Patient Name
   - Pharmacy Name/Address
   - Total Charge
   - Drug Name and NDC Number
   - NPI Number
   - Quantity
   - Fill Date
   - Rx Number
   - Days Supply

   If any of your receipts do not have **required** information, ask your pharmacist to provide you with the missing information.

   Write that information on your receipt(s). If not completed, the claim will be sent back for the required information.
3. Call the customer service number on your ID card if you have any questions.
4. Have your pharmacist call 800.821.4795 if he/she has any questions.
5. Send completed form to:

   Prime Therapeutics
   P.O. Box 14624
   Lexington, KY 40512-4624

EXAMPLE
of how to complete the Prescription Drug Claim Form.

1 Rx Number 0 0 0 0 0 6 0 1 1 4 8 1

Date Filled 0 1 / 1 2 / 0 5

Quantity 30 Day Supply 3 0

Name of Medication "Drug Name"

NDC Number 0 0 1 2 3 4 5 6 7 3 1

(Your pharmacist can provide the NDC number identifying the drug.)

NPI Number 9 2 1 5 2 4 1 1 6 3

Prescription Cost $ 2 0 5 . 1 4

Balance Due $ 2 0 5 . 1 4

Is this prescription claim for a compound medication?
❑ Yes ❑ No

Note: If yes, make sure your pharmacist completes the information below.

Compound Information:
If a compound prescription, please enter all information per drug used.

Compound Prescriptions
For pharmacy use only

NDC Number	Drug Ingredient	Quantity	Charge

Rx 1

Pharmacy Receipts Only

Tape or glue one pharmacy receipt in this space.
If you prefer, staple your receipts to the top of this form.

Keep a copy of your receipt(s) for your records.

Rx 2

Pharmacy Receipts Only

Tape or glue one pharmacy receipt in this space.
If you prefer, staple your receipts to the top of this form.

Keep a copy of your receipt(s) for your records.

3272 OK © Prime Therapeutics LLC 01/12

BlueCross BlueShield of Oklahoma

1215 S. Boulder | P.O. Box 3283 | Tulsa, OK 74102-3283

HEALTH BENEFITS CLAIM FORM

SEE INSTRUCTIONS ON REVERSE SIDE

PATIENT INFORMATION *A SEPARATE CLAIM FORM MUST BE COMPLETED FOR EACH PATIENT*

LAST NAME OF PATIENT	FIRST	MIDDLE INITIAL	SEX ☐ M ☐ F	RELATIONSHIP TO MEMBER	DATE OF BIRTH (MM/DD/YY)

MEMBER INFORMATION

LAST NAME OF MEMBER	FIRST	MIDDLE INITIAL	EMPLOYER
MEMBER'S ADDRESS (STREET, CITY, STATE, ZIP CODE)			

IDENTIFICATION NUMBER *COPY THIS FROM YOUR BLUE CROSS AND BLUE SHIELD IDENTIFICATION CARD*

IDENTIFICATION NUMBER (FROM BLUE CROSS AND BLUE SHIELD CARD)	GROUP NUMBER

ACCIDENT INFORMATION

IS CLAIM FOR ACCIDENTAL INJURY? ☐ YES ☐ NO	WAS ACCIDENTAL INJURY WORK RELATED? ☐ YES ☐ NO	DATE OF ACCIDENTAL INJURY
WHERE DID THE ACCIDENTAL INJURY OCCUR?		
DESCRIBE THE TYPE OF ACCIDENTAL INJURY		

DESCRIPTION OF ILLNESS

BRIEFLY DESCRIBE THE CONDITIONS FOR WHICH SERVICES WERE RENDERED OR DRUGS PRESCRIBED

OTHER INSURANCE INFORMATION

DOES PATIENT HAVE OTHER HEALTH INSURANCE? ☐ YES ☐ NO		COVERAGE IS: ☐ SINGLE ☐ FAMILY	MEDICARE? ☐ YES ☐ NO
POLICY HOLDER'S NAME	OTHER INSURANCE CARRIER'S NAME	POLICY NUMBER	EFFECTIVE DATE OF COVERAGE (MM/DD/YY)
OTHER INSURANCE CARRIER'S PHONE NUMBER	OTHER INSURANCE CARRIER'S ADDRESS		

AGREEMENT AND SIGNATURE OF MEMBER *CLAIM WILL NOT BE ACCEPTED WITHOUT SIGNATURE OF MEMBER*

I certify that the above information is correct and that the bills attached were incurred by the patient listed above. I authorize any medical professional, hospital, medical or medically related facility, pharmacy, government agency, insurance company or other person or firm to provide Blue Cross and Blue Shield information, including copies of records, concerning advice, care or treatment provided the patient above including, without limitation, information relating to mental illness, use of drugs or alcohol, upon presentation of a photocopy of this signed authorization. I understand that such information will be used by Blue Cross and Blue Shield for the purpose of evaluating a claim for insurance benefits for services provided to the patient named above, I understand that I or any authorized representative will receive a copy of this authorization upon request. This authorization is valid from the date signed until revoked in writing.

MEMBER'S SIGNATURE	MEMBER'S DAYTIME PHONE NUMBER	DATE SIGNED (MM/DD/YY)
X		

3.004 (04/06)

Follow these steps for fast, efficient service!

1. Please remember to present your Blue Cross and Blue Shield of Oklahoma identification card whenever you receive health care services.
2. Claims for both inpatient and outpatient hospital services must be submitted **by the hospital** directly to Blue Cross and Blue Shield of Oklahoma.
3. Physicians and certain other health care providers who are members of Blue Cross and Blue Shield of Oklahoma's participating provider network (PAR-NET, PPO, Primary Care Physician) also will file your claim for you. **If your doctor or other health care provider files your claim, it's important NOT to file the same claim yourself. Duplicate claims will delay processing.**
4. If you need to file your own claim, please complete the reverse side of this form. **You can help us avoid processing delays by answering all the questions completely. Be sure to complete a separate claim form for EACH patient.**
5. **Do you have other group health insurance or Medicare?**
   If so, and the other insurance carrier is primary (meaning that carrier pays first), you will need to file the claim with that carrier first. After you receive an "Explanation of Benefits" form from the other carrier (or Medicare), send a copy of it, copies of your itemized medical statements and a completed claim form to Blue Cross and Blue Shield of Oklahoma for processing.
6. **Always remember to include an itemized statement from your physician or other health care provider.** Be sure to keep a copy for your files. Balance due statements, payments on account, cancelled checks, receipts and ledger cards are not accepted.

   Statements for **medical care** should include:
   - Provider's name, address and telephone number
   - Full name of patient (bills listing only the party responsible for payment are not acceptable)
   - Place where service was rendered (hospital, emergency room, physician's office)
   - Diagnosis of illness or accidental injury for each service rendered (if accidental injury, give the date it occurred)
   - Date, description and charge for each service rendered

   Statements for **prescription drugs** should include:
   - Name and address of pharmacy
   - Full name of patient
   - Date of purchase
   - Name of drug purchased and prescription number
   - Total charge for each prescription

   A diagnosis of illness for which each drug was prescribed is required on "Description of Illness" section on front of claim form; a separate statement is required for each drug; cash register/credit card receipts or personal listings of drugs purchased cannot be accepted.

   Statements for **ambulance service** should include:
   - Date the service was rendered
   - Base rate and mileage
   - Place where patient was picked up and final destination
   - Date of admittance to hospital
   - Indicate if the ambulance service was due to accidental injury. If so, provide the date of the accidental injury
   - If not accidental injury related, type of illness

   Statements for rental/purchase of **durable medical equipment** should include:
   - The charge for equipment and whether it is being purchased or rented. (The cost to purchase the equipment should also be indicated on a rental claim. If the equipment is for long-term use, please remember that rental of durable medical equipment is paid only up to the purchase price of the equipment.)
   - Prescription and letter of medical necessity from the attending physician which includes the length of time the equipment will be medically necessary.

7. If you have questions or would like to report a change of address, please call a Blue Cross and Blue Shield of Oklahoma Customer Service Representative in Tulsa at (918) 560-3500 or in Oklahoma City at (405) 841-9596. Call Monday through Friday from 9 a.m. to 4:30 p.m.

8. Please mail claim forms and statements to:
   BLUE CROSS AND BLUE SHIELD OF OKLAHOMA

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE OKLAHOMA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of Oklahoma who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Oklahoma Life and Health Insurance Guaranty Associations. The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its' other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The Oklahoma Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Oklahoma. You should not rely on coverage by the Oklahoma Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. *However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.*

The Oklahoma Life and Health Insurance Guaranty Association
201 Robert S. Kerr, Suite 600
Oklahoma City, Oklahoma 73102

Oklahoma Department of Insurance
P.O. Box 53408, Oklahoma City, Oklahoma 73152-3408

The state law that provides for this safety-net coverage is called the Oklahoma Life and Health Insurance Guaranty Association Act. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.

(please turn to back of page)

COVERAGE

Generally, individuals will be protected by the Oklahoma Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are **not** protected by this Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose Guaranty Association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Association also does **not** provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contract holders, not individuals).

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the Association is obligated to pay out: The Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Association will pay a maximum of $300,000 – no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. Within this overall $300,000 limit, the Association will not pay more than $100,000 in cash surrender values, $300,000 in health insurance benefits, $300,000 in present value of annuities, or $300,000 in life insurance death benefits – again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages.

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BlueCross BlueShield of Oklahoma

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

PERSONAL BLUE
INDIVIDUAL CONVERSION CONTRACT

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

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

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

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

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

- NON-PAYMENT OF DUES;
- FRAUD;
- TERMINATION OF THE PARTICULAR TYPE OF COVERAGE, OR ALL COVERAGE, IN THE INDIVIDUAL MARKET; OR
- MOVEMENT OF YOU AND/OR YOUR DEPENDENTS OUTSIDE THE PLAN'S SERVICE AREA.

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.

THIS CONTRACT MAY NOT BE CANCELLED BY YOU OR THE PLAN DURING A COVERAGE PERIOD, EXCEPT FOR NON-PAYMENT OF DUES, OR FOR FRAUD OR MATERIAL MISREPRESENTATION MADE IN ANY STATEMENT, APPLICATION, CLAIM OR OTHER FORM SUBMITTED TO OBTAIN THIS CONTRACT OR ANY OF ITS BENEFITS.

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

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

Keep your health care protection. Please notify the Plan of any change in your address. You should also notify the Plan immediately if you become eligible to enroll for health coverage through another program underwritten by Blue Cross and Blue Shield of Oklahoma or any of its subsidiaries.

Upon change of your marital status, either by marriage or divorce, the Plan must receive your written notification within 31 days. Upon your death, a surviving Subscriber should provide written notification to the Plan within 31 days in order that his/her membership rights may be continued.

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

GENERAL: In consideration of the Membership Application and payment of Dues by the Member covered hereunder, Blue Cross and Blue Shield of Oklahoma (the Plan) agrees to make available to the Member, and any eligible Subscriber hereunder, a prepaid program of health care Benefits provided, subject to and administered in accordance with this Contract. The whole Contract herein consists of the Membership Application, the Identification Card and this Contract, including any provisions which may be added by Amendment or Endorsement.

The issuance of this Contract to you certifies that the Plan has accepted your Application and that you, the Member named in the Identification Card, and your Dependents, if any, listed in your Application or any supplemental Application accepted by the Plan, are entitled to the Benefits set forth in this Contract.

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

President of Blue Cross and Blue Shield of Oklahoma

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SECTION I — IMPORTANT INFORMATION

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

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

A. THE BLUECHOICE PPO PROVIDER NETWORK

The BlueChoice PPO Provider Network is comprised of health care Providers who have agreed to work with Blue Cross and Blue Shield of Oklahoma to help keep down the cost of health care. Subscribers can take advantage of their highest level of Benefits by using BlueChoice PPO Providers whenever possible.

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

B. HOW YOUR PERSONAL BLUE COVERAGE WORKS

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

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

In contrast, when care is received from a Provider who is not a member of the BlueChoice PPO Provider Network, a *higher* Coinsurance and Stop-Loss Limit will apply to most Covered Services. Also, if you receive *Inpatient* care from a Hospital that is not a BlueChoice PPO Provider, you will be responsible for a separate $300 Deductible for each Hospital Admission (in addition to your Benefit Period Deductible).

IMPORTANT:

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

C. BLUETRADITIONAL PARTICIPATING PROVIDER NETWORK

Through special arrangements with Blue Cross and Blue Shield of Oklahoma, many Oklahoma Hospitals, Physicians, and other Providers outside the BlueChoice PPO Provider 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 BlueChoice PPO Providers, using a BlueTraditional Provider offers some of the same advantages available to you within the BlueChoice PPO Provider network:

1. A BlueTraditional Provider will file your claims for you (just as a BlueChoice PPO Provider would do).
2. Payment for Covered Services will be sent directly to the BlueTraditional Provider.
3. BlueTraditional Providers have agreed to charge Plan Subscribers no more than a "Maximum Reimbursement Allowance" for Covered Services. If your BlueTraditional Provider charges more than our allowance for Covered Services, you aren't responsible for the difference. **However, you will be responsible for the difference, if any, between the BlueTraditional allowance and the "Allowable Charge" which a BlueChoice PPO Provider would have accepted for the same services.**

D. THE BLUECARD PROGRAM

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

1. **Finding a PPO Physician or Hospital**

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

2. **Available Care Coast to Coast**

   Show your Identification Card to any Blue Cross and Blue Shield PPO Physician or Hospital across the USA. You have plenty to choose from – Blue Cross and Blue Shield PPO networks are available to 95% of the U.S. population. The PPO Physicians and Hospitals can verify your membership eligibility and coverage with Blue Cross and Blue Shield of Oklahoma. When you visit a PPO doctor or Hospital, you should have no claim forms to file and no billing hassles.

3. **Remember to Always Carry the BlueCard**

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

   b. **Some local variations in Benefits do apply.** If you need more information, call Blue Cross and Blue Shield of Oklahoma today. Now, home is where the card is.

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

HOW THE BLUECARD PPO PROGRAM WORKS

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

E. YOUR PRESCRIPTION DRUG PROGRAM

Blue Cross and Blue Shield of Oklahoma has contracted with a network of Participating Pharmacies to help hold the line on the increasing costs of Prescription Drugs. This network of Participating Pharmacies utilizes a special processing system for Prescription Drug claims – called *LINCS*$_{RX}$. This system is your "key" to simplified claims processing.

HOW YOUR PRESCRIPTION DRUG PROGRAM WORKS

- ✓ Show your Personal Blue Identification Card (with the *LINCS*$_{RX}$ logo on the bottom) to your Pharmacy.
- ✓ If you choose a Participating Pharmacy, you will receive a discounted price for your prescriptions and your claims are filed automatically!
- ✓ Blue Cross and Blue Shield of Oklahoma will process your claim, subtract any Deductible and/or Coinsurance amounts which apply to your covered prescriptions, and forward the balance directly to you.

The Participating Pharmacy network includes more than 700 Pharmacies in Oklahoma. Just look for the *LINCS*$_{RX}$ symbol on display at your Pharmacy.

In addition, Blue Cross and Blue Shield of Oklahoma Subscribers have instant access to more than 54,000 Pharmacies in the Plan's nationwide Pharmacy network. This extensive network includes most major chains and many independently owned Pharmacies.

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 one of the following numbers:

- In the Tulsa area: (918) 560-3535
- In the Oklahoma City area: (405) 841-9596
- All other areas: 1-800-94 BLUES (1-800-942-5837)

If you find it necessary to purchase your prescriptions from a Pharmacy who does not utilize the *LINCS$_{RX}$* system, *or if you do not have your Identification Card with you when you pay for 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.

F. SELECTING A PROVIDER

Upon enrollment, you will receive a directory of BlueChoice PPO Providers. Providers are listed alphabetically and by specialty. The directory also indicates the Hospitals where each Physician practices.

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

When you call Blue Cross and Blue Shield of Oklahoma, ask our Customer Service Representative whether or not the Provider is a BlueChoice PPO Provider. In the Tulsa area, call (918) 560-3535, and in Oklahoma City, call (405) 841-9596. In other areas, simply call our toll-free number: 1-800-94 BLUES (1-800-942-5837). A listing of Oklahoma BlueChoice PPO Providers is also available on-line through the Blue Cross and Blue Shield of Oklahoma website at www.bcbsok.com.

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

Remember that you receive the highest level of Benefits under this program when you use BlueChoice PPO Providers.

G. MEDICAL NECESSITY LIMITATION

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

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

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

H. PRECERTIFICATION

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

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

3. If you are admitted to the Hospital for Emergency Care, and there is not time to obtain Precertification, you will not be subject to the $500 Benefit reduction *if you or your Provider notifies the Plan within two working days following your emergency admission.*

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

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

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

7. The Plan will not restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a Provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods.

I. CONCURRENT REVIEW AND CASE MANAGEMENT

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

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

J. ALLOWABLE CHARGE

1. To take full advantage of the negotiated pricing arrangements in effect between Blue Cross and Blue Shield of Oklahoma and our BlueChoice PPO Providers, it is imperative that you use BlueChoice PPO Providers whenever possible. Using a BlueChoice PPO Provider offers you the following advantages:

   a. BlueChoice PPO Providers have agreed to hold the line on health care costs by providing special prices for our Personal Blue Subscribers. A BlueChoice PPO Provider will accept this negotiated price (called the **"Allowable Charge"**) as payment for Covered Services. This means that, if a BlueChoice PPO Provider bills you more than the Allowable Charge for Covered Services, ***you are not responsible for the difference*.**

   b. Blue Cross and Blue Shield of Oklahoma will calculate your Benefits based on this "Allowable Charge". We will deduct any charges for services which aren't eligible under your coverage, then subtract your Deductible and/or Coinsurance amounts which may be applicable to your Covered Services. We will then determine your Benefits under the Contract, and direct any payment to your BlueChoice PPO Provider.

> REMEMBER**...**
>
> You receive the maximum Benefits allowed whenever you utilize the services of a BlueChoice PPO Provider.

2. Your program contains special provisions (Benefit reductions) which apply whenever you use Providers who are not members of the BlueChoice PPO Provider Network. If you use an Out-of-Network Provider, your Benefits will be determined as follows:

   a. Blue Cross and Blue Shield of Oklahoma will determine the Allowable Charge for your out-of-network claims ***based upon what we would have reimbursed a BlueChoice PPO Provider for the same service***. You will be responsible for the following:

      1) Charges for any services which are not covered under your Contract.

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

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

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

   b. In certain instances, your services may be rendered by a Provider who has a Participating Provider Agreement (other than a BlueChoice PPO Participating Provider Agreement) with Blue Cross and Blue Shield of Oklahoma. These Providers (called BlueTraditional Providers) have agreed to charge Plan Subscribers no more than a "Maximum Reimbursement Allowance" for Covered Services. If you receive Covered Services from a BlueTraditional Provider, you will be responsible for the amounts over the "Allowable Charge", *up to but not exceeding* the "Maximum Reimbursement Allowance" specified in their Participating Provider Agreement.

K. ENDORSEMENTS

Because of some state laws or changes in your program, provisions called "endorsements" may be added to your Contract.

Be sure to check for an "endorsement". It changes provisions or Benefits in the Contract.

L. IDENTIFICATION CARD

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

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

Carry your card at all times. In case of loss, you can still use your coverage. You can replace your card faster, however, if you know your identification number. (In most cases, your identification number is the Member's Social Security Number.)

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

M. QUESTIONS

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

You usually will be able to answer your health care Benefit questions by referring to this Contract. If you need more help, please call a Customer Service Representative at one of the following numbers:

- In the Tulsa area: (918) 560-3535
- In the Oklahoma City area: (405) 841-9596
- All other areas: 1-800-94 BLUES (1-800-942-5837)

Or you can write:

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

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

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

SECTION II — DEFINITIONS

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

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

   a. **BlueChoice PPO Providers –** the Provider's usual charge, not to exceed the amount the Provider has agreed to accept as payment for Covered Services in accordance with a BlueChoice PPO Provider Agreement.

   b. **Out-of-Network Providers –** the Provider's usual charge, up to the amount that the Plan would reimburse a BlueChoice PPO Provider for the same service.

   NOTE: For Covered Services received outside the state of Oklahoma, the "Allowable Charge" may be determined by the on-site Blue Cross and Blue Shield Plan. Payment will be based upon the Provider payment arrangements in effect between the Provider and the on-site Plan.

2. **AMBULATORY SURGICAL FACILITY –** a Provider with an organized staff of Physicians which:

   a. Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;

   b. Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;

   c. Does not provide Inpatient accommodations; and

   d. Is not, other than incidentally, a facility used as an office or clinic for the private practice of a Physician or other Provider.

3. **BENEFIT PERIOD –** the period of time during which you receive Covered Services that we will pay for.

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

5. **BLUECHOICE PPO PROVIDER –** a Provider who has entered into an agreement with the Plan to bill the Plan directly for Covered Services, and to accept the Plan's allowance as payment for such Covered Services.

6. **BLUETRADITIONAL PROVIDER –** a Provider who has entered into an agreement with the Plan to bill the Plan directly for Covered Services. A BlueTraditional Provider may or may not be a BlueChoice PPO Provider.

7. **CALENDAR YEAR –** the period of 12 months commencing on the first day of January and ending on the last day of the following December.

8. **COINSURANCE –** the *percentage* of Allowable Charges for Covered Services for which the Subscriber is responsible.

9. **COMMUNITY HOME HEALTH CARE AGENCY –** a Provider which provides nurses who visit the patient's home to give nursing and other needed care. This agency sees that each patient gets all care ordered by the Physician.

10. **COMPLAINT/GRIEVANCE –** any oral or written expression of a misunderstanding or dissatisfaction regarding a Blue Cross and Blue Shield of Oklahoma medical or non-medical activity, service, or procedure.

11. **CONTRACT –** the agreement (including the Membership Application, Identification Card, and any endorsements) between you and the Plan, referred to as the Individual Conversion Contract.

12. **COVERED SERVICE –** a service or supply shown in the Contract and given by a Provider for which we will provide Benefits.

13. **CUSTODIAL CARE –** aid to patients who need help with daily tasks like eating, dressing and walking. Custodial Care does not directly treat an injury or illness.

14. **DEDUCTIBLE –** a specified amount of Covered Services that you must incur before the Plan will start to pay its share of the remaining Covered Services.

15. **DEPENDENT –** a Subscriber other than the Member as shown in the ***Eligibility*** section.

16. **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.

    a. Radiology, ultrasound and nuclear medicine

    b. Laboratory and pathology

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

17. **DUES –** the total of the amounts charged for the Member's coverage under this Contract.

18. **DURABLE MEDICAL EQUIPMENT–** items which can withstand repeated use; meet the Plan's criteria of Medical Necessity for the given diagnosis; are not useful to the patient in the absence of illness, injury or disease; and are appropriate for use in an Outpatient setting.

19. **EFFECTIVE DATE –** the date your coverage begins as shown on your Identification Card.

20. **ELIGIBLE PERSON –** a person entitled to apply to be a Member as specified in the ***Eligibility*** section.

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

    a. serious jeopardy to the Subscriber's health;

    b. serious impairment to bodily function; or

    c. serious dysfunction of any bodily organ or part.

22. **EXPERIMENTAL/INVESTIGATIONAL –** a drug, device or medical treatment or procedure is Experimental or Investigational if the Plan determines that:

    a. the drug or device cannot be lawfully marketed without approval of the U. S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

    b. Reliable Evidence shows that the drug, device 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

c. Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, 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.

"*Reliable Evidence*" shall mean only:

1) published reports and articles in the authoritative medical and scientific literature;

2) the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure; or

3) the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure.

23. **HOSPICE –** a Provider which provides an integrated set of services designed to provide palliative and supportive care to terminally ill patients and their families.

24. **HOSPITAL –** a Provider that is a short-term, acute care, general Hospital which:

a. Is licensed;

b. Mainly provides Inpatient diagnostic and therapeutic services under the supervision of Physicians;

c. Has organized departments of medicine and major Surgery;

d. Provides 24-hour nursing service; and

e. Is not, other than incidentally, a:

1) Skilled Nursing Facility;

2) Nursing home;

3) Custodial Care home;

4) Health resort;

5) Spa or sanitarium;

6) Place for rest;

7) Place for the aged;

8) Place for the treatment of Mental Illness;

9) Place for the treatment of alcoholism or drug abuse;

10) Place for the provision of Hospice care;

11) Place for the provision of rehabilitation care;

12) Place for the treatment of pulmonary tuberculosis.

25. **HOSPITAL ADMISSION–** the period from your entry (admission) into a Hospital for Inpatient treatment until your discharge.

26. **IDENTIFICATION CARD –** the card issued to you, bearing your name, identification number and Effective Date.

27. **INCURRED –** a charge is Incurred on the date you receive a service or supply for which the charge is made.

28. **INDIVIDUAL CONVERSION –** a classification of individual coverage other than Group for which the individual Member pays the Dues directly to the Plan or its depository.

29. **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.

30. **LICENSED PRACTICAL OR VOCATIONAL NURSE (LPN or LVN) –** a licensed nurse with a degree from a school of practical or vocational nursing.

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

32. **MATERNITY SERVICES –** care required as a result of being pregnant, including prenatal care and postnatal care.

33. **MEDICAL CARE –** professional services given by a Physician or other Provider to treat illness or injury.

34. **MEDICALLY NECESSARY (or MEDICAL NECESSITY) –** a service or supply given by a Hospital, Physician, or other Provider which we determine is:

    a. Appropriate for symptoms and diagnosis to treat the condition, illness, disease or injury; and

    b. In line with standards of good medical practice; and

    c. Not primarily for you or your Provider's convenience; and

    d. The most appropriate supply or level of service which can be safely provided to you. When applied to the care of an Inpatient, this means that your condition or the services you need require acute care as a bed patient and that you cannot receive safe or adequate care as an Outpatient.

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

36. **MEMBER –** an Eligible Person who has enrolled for coverage.

37. **MEMBER AND CHILDREN COVERAGE –** coverage under this Contract for the Member and his or her Dependent child(ren)

38. **MEMBER ONLY COVERAGE –** coverage under this Contract for the Member only.

39. **MEMBER, SPOUSE AND CHILDREN COVERAGE –** coverage under this Contract for the Member, his or her spouse and Dependent child(ren)

40. **MEMBER AND SPOUSE ONLY COVERAGE –** coverage under this Contract for the Member and his or her spouse only.

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

42. **ORGAN PROCUREMENT SERVICES –** the services provided to match the human organ donor to the transplant recipient, surgically remove the organ from the donor and transport the organ to the location of the recipient within 24 hours after the match is made.

43. **ORTHOGNATHIC SURGERY–** services or supplies received for corrections of deformities of the jaw, including the surgical repositioning of portions of the upper or lower jaws or the bodily repositioning of entire jaws.

44. **OUT-OF-NETWORK PROVIDER –** a Provider that has not entered into an agreement with the Plan to be a part of its BlueChoice PPO Provider Network.

45. **OUTPATIENT –** a Subscriber who receives services or supplies while not an Inpatient.

46. **PARTICIPATING PHARMACY –** a Pharmacy that has entered into a Participating Pharmacy Agreement with the Plan.

47. **PHARMACY –** a person, firm or corporation duly authorized by state law to dispense Prescription Drugs.

48. **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.

49. **PLAN –** Blue Cross and Blue Shield of Oklahoma.

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

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

51. **PREEXISTING CONDITION –** a condition or complication thereof is considered *"preexisting"* if any of the following events occurred within 12 months before the Subscriber's Effective Date:

    a. Medical expenses were Incurred; or

    b. Medical advice or diagnosis was given; or

    c. Medication was taken or prescribed; or

    d. Treatment was recommended by or received from a Physician or other Provider; or

    e. The Subscriber had an awareness of symptoms.

52. **PRESCRIPTION DRUG –** any medicinal substance the label of which under the Federal Food, Drug and Cosmetic Act is required to bear the legend: "Caution: Federal Law prohibits dispensing without prescription.

53. **PROOF OF LOSS –** a formal statement or claim regarding a loss which provides sufficient information to allow the Plan to determine its liability for Covered Services. This includes: a completed claim form; the Provider's itemized statement of services rendered and related charges; and medical records, when requested by the Plan, as provided under the utilization review procedures of this Contract.

54. **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.

55. **REGISTERED NURSE (RN) –** a licensed nurse with a degree from a school of nursing.

56. **ROUTINE NURSERY CARE –** ordinary Hospital nursery care of the newborn Subscriber.

57. **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:

    a. Custodial Care, ambulatory, or part-time care; or

b. Treatment for Mental Illness, alcoholism, drug abuse or pulmonary tuberculosis.

58. **STOP-LOSS LIMIT –** a specified dollar amount of Covered Services which are reimbursed at less than 100% of the Allowable Charge to or on behalf of a Subscriber during a Benefit Period. When the Stop Loss Limit is reached, the level of Benefits is increased as specified in the Schedule of Benefits.

59. **SUBSCRIBER –** the Member and each of his or her Dependents (if any) enrolled under this Contract.

60. **SURGERY –** the performance of generally accepted operative and other invasive procedures;

    a. The correction of fractures and dislocations;

    b. Usual and related preoperative and postoperative care.

61. **THERAPY SERVICE –** the following services and supplies ordered by a Physician when used to treat and promote your recovery from an illness or injury:

    a. **Chemotherapy –** the treatment of malignant disease by chemical or biological antineoplastic agents.

    b. **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.

    c. **Occupational Therapy –** treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role.

    d. **Physical Therapy –** the treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles, and devices to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of body part.

    e. **Radiation Therapy –** the treatment of disease by x-ray, radium, or radioactive isotopes.

    f. **Respiratory Therapy –** introduction of dry or moist gases into the lungs for treatment purposes.

    g. **Speech Therapy –** treatment for the correction of a speech impairment resulting from disease, Surgery, injury, congenital and developmental anomalies, or previous therapeutic processes.

62. **TOTALLY DISABLED (or Total Disability) –** a condition resulting from disease or injury, concerning which a Physician has provided proof satisfactory to the Plan that:

    a. the Subscriber is unable to perform the substantial duties of any occupation or business for which qualified and is not in fact engaged in any occupation for wages or profit; or

    b. if the Subscriber does not usually engage in any occupation for wages or profit, the Subscriber is substantially unable to engage in the normal activities of an individual of the same age and sex.

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

SECTION III — ELIGIBILITY

This section explains *who* is eligible for coverage under this Contract; *how* and *when* your coverage becomes effective; and *how* to add or delete coverage for Dependents.

A. ELIGIBLE PERSON

If you are an Oklahoma resident under age 65, you are eligible to apply for coverage under this Contract.

B. ELIGIBLE DEPENDENT

An Eligible Dependent is defined as:

1. Your spouse (under the age of 65 at the time of enrollment); and
2. Your unmarried child, including a newborn child, adopted child, stepchild, or other child for whom you or your spouse is legally responsible, including a child on whose behalf a qualified medical child support order (QMSCO) has been issued.
    a. Unmarried Dependent children under age 19 are eligible for coverage until January 1 following the year during which he/she reaches the age of 19, provided the child has not reached age 19 before his/her Effective Date.
    b. Unmarried Dependent children who are medically certified as Totally Disabled and dependent upon you or your spouse are eligible for coverage regardless of age.

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

The Plan also reserves the right to review a Physician's certificate of disability and/or request medical records 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 Dependent is Totally Disabled.

C. EFFECTIVE DATE

1. In order to be covered, you must submit an application and furnish an acceptable Statement of Health for yourself and each of your Eligible Dependents, when required in accordance with the Plan's underwriting and enrollment regulations. If the application and Statement of Health are accepted, the Effective Date will be determined by the Plan.
2. You may apply to add Dependents to your coverage at any time. However, you must submit an acceptable Statement of Health to the Plan for each person to be added to your coverage (see exceptions below for newborn and adopted children). If the application and Statement of Health are accepted, the Effective Date for your Dependents will be determined by the Plan.
3. If you are enrolled under Member Only Coverage, you may add coverage for a newborn child without submitting a Statement of Health. However, your application to add coverage for the newborn must be received by the Plan within 31 days of the child's birth; and you must make the required contribution for such coverage from the date of birth. The Effective Date for the newborn child will be his/her birth date.
4. If you are enrolled under Member and Spouse Only Coverage, 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 of the child's birth; and you must make the required contribution for such coverage from

the date of birth. A Statement of Health will not be required if the application is received within 31 days of the child's birth.

5. If you are enrolled under Member and Children Coverage or Member, Spouse and Children Coverage, no application or Statement of Health will be required to add coverage for a newborn child. However, you must notify the Plan of the child's birth. The Effective Date for the newborn will be the child's birth date.

6. Coverage may be added for an adopted child, including a child placed for adoption in the Member's custody. If application to add the child is received by the Plan within 31 days of the date the child is placed in the Member's custody, the Effective Date will be the date the Member assumed the physical custody of the adopted child and the financial responsibility for the support and care of the adopted child. A copy of the court order or adoption papers must be submitted to the Plan with the application.

   Subject to the Exclusions, conditions and limitations of this Contract, coverage for an adopted child will include the actual and documented medical costs associated with the birth of an adopted child who is 18 months of age or younger. You must provide copies for 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.

7. You can change coverage to delete Dependents. The change will be effective at the end of the coverage period for which payment of Dues have been paid, except that in the case of divorce the change will be effective the date the divorce is granted.

8. In the event of a divorce, your spouse may wish to continue Blue Cross and Blue Shield of Oklahoma coverage. He/she may apply for separate Individual Conversion coverage without submitting a Statement of Health if application is received by the Plan no later than 31 days after the divorce is granted. Your Dependent children may continue to be eligible under your coverage or your spouse may obtain their own Dependent coverage.

9. Your spouse and Dependent children become ineligible for coverage under your Contract upon your death. However, your spouse and Dependent children may be eligible to change to a new Individual Conversion membership. To ensure continuous protection, the Plan must receive their application within 31 days following your death. Otherwise, a Statement of Health will be required for your spouse and each Dependent child.

D. **DELAYED EFFECTIVE DATE**

The Effective Date for a Subscriber will be delayed if the Subscriber (except for a newborn child or adopted child) is confined in a Hospital on the day that would otherwise be the Subscriber's Effective Date. The Effective Date will be the date of final discharge from the Hospital. However, this provision will not apply to a Subscriber who was continuously enrolled in any coverage underwritten by Blue Cross and Blue Shield of Oklahoma (or other Blue Cross and Blue Shield coverage) immediately before his/her Effective Date.

In no event will a Dependent's coverage begin before the Member's Effective Date.

SECTION IV – SCHEDULE OF BENEFITS

This section shows how much we pay for Covered Services described in the "***Comprehensive Health Care Services***" section that follows.

BENEFIT PERIOD Calendar Year.

DEDUCTIBLE

Out-of-Network Hospital Deductible $300 per Hospital Admission.

This Deductible applies to all Covered Services Incurred during your admission to a Hospital which is not a BlueChoice PPO Provider.

Benefit Period Deductible $1,000 per Benefit Period per Subscriber.

The Benefit Period Deductible is in addition to the Out-of-Network Hospital Deductible described above.

Deductibles applies to all Covered Services except:

- Routine Nursery Care (*$300 Out-of-Network Hospital Deductible does apply*);
- Annual prostate cancer screening (limited to $65 per screening);
- Covered childhood immunizations (for Subscribers under age 19);
- Routine Low-Dose Mammography (limited to $115 per screening);
- Ambulance Services.

Expenses Incurred for Covered Services in the last three months of a Benefit Period which were applied to that Benefit Period's Deductible will be applied to the Deductible of the next Benefit Period.

FAMILY DEDUCTIBLE If your coverage includes your Dependents, then:

- no more than three times the individual Deductible must be satisfied in each Benefit Period for all family Members covered under your membership; and
- if two or more Subscribers under your membership incur expenses for Covered Services as a result of injuries received in the same accident, only one Deductible will be applied to the aggregate of such charges.

No family Subscriber will contribute more than the individual Deductible amount.

The Family Deductible provisions described above will not include the Out-of-Network Hospital Deductible per Inpatient admission for services rendered by an Out-of-Network Hospital.

STOP-LOSS LIMIT

- **BlueChoice PPO Provider Services –** When you have Incurred $10,000 in excess of the Deductible amount for Covered Services provided by BlueChoice PPO Providers during a Benefit Period, the amount of Allowable Charges covered by the Plan on your behalf will increase to 100% during the remainder of the Benefit Period.
- **Out-of-Network Provider Services –** When you have Incurred $20,000 in excess of the Deductible amount for Covered Services provided by Out-of-Network Providers during a Benefit Period, the amount of Allowable charges covered by the Plan on your behalf will increase to 100% during the remainder of the Benefit Period for Out-of-Network Providers services.

These Stop-Loss Limits are cumulative; i.e., expenses Incurred either inside or outside the BlueChoice PPO Provider network count toward both Stop-Loss Limits specified above. However, the $20,000 Stop-Loss Limit will apply any time you receive services outside the BlueChoice PPO Provider network, even though you may have previously satisfied the $10,000 Stop-Loss Limit for BlueChoice PPO Provider services.

These Stop-Loss Limits and Benefit percentage amount specified above do not apply to expenses Incurred for Psychiatric Care Services.

MAXIMUM

$500,000 per lifetime per Subscriber, including:

- $25,000 per lifetime per Subscriber for Psychiatric Care Services;
- any other limitations specifically stated in this Contract.

This amount includes the Benefits provided under any other Contract or agreement underwritten by the Plan.

BENEFIT PERCENTAGE AMOUNT

The following chart shows the amount of Allowable Charges Covered by the Plan through payments and/or contractual arrangements with Providers. These amounts apply only after your Deductible and/or Coinsurance amount has been satisfied.

The "BlueChoice PPO Provider Services" percentage shown is applicable to Covered Services received from a BlueChoice PPO Provider.

The amounts shown for "Out-of-Network Provider Services" apply whenever you receive care from a Provider who is not a member of the BlueChoice PPO Provider Network.

COVERED SERVICES (Subject to the ***Comprehensive Health Care Services*** section which follows)	**AMOUNT:** BlueChoice PPO Provider Services	Out-of-Network Provider Services
HOSPITAL SERVICES	80%	70%
SURGICAL/MEDICAL SERVICES		
Covered Childhood Immunizations (Limited to Subscribers under age 19)	100%	100%
All Other Covered Surgical/Medical Services	80%	70%
OUTPATIENT DIAGNOSTIC SERVICES		
Routine Low-Dose Mammography (Limited to $115 per screening)	100%	100%
All Other Covered Outpatient Diagnostic Services	80%	70%
OUTPATIENT THERAPY SERVICES	80%	70%
Radiation Therapy Chemotherapy Physical Therapy and Occupational Therapy Respiratory Therapy Dialysis Treatment		
MATERNITY SERVICES	80%	70%
MASTECTOMY AND RECONSTRUCTIVE SURGICAL SERVICES	80%	70%
HUMAN ORGAN AND TISSUE TRANSPLANT SERVICES	80%	70%
AMBULATORY SURGICAL FACILITY SERVICES	80%	70%
PSYCHIATRIC CARE SERVICES	50%	50%
AMBULANCE SERVICES	100%	100%
PRIVATE DUTY NURSING SERVICES	80%	70%
REHABILITATION CARE	80%	70%
SKILLED NURSING FACILITY SERVICES	80%	70%

COVERED SERVICES (Subject to the ***Comprehensive Health Care Services*** section which follows)	**AMOUNT**: **BlueChoice PPO Provider Services**	**Out-of-Network Provider Services**
HOME HEALTH CARE SERVICES	80%	70%
PRESCRIPTION DRUGS	70%*	70%
ALL OTHER COVERED SERVICES	80%	70%

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

SECTION V —
COVERED COMPREHENSIVE HEALTH CARE SERVICES

This section states the Covered Services and Benefits of this Contract. The following are Covered Services:

A. HOSPITAL SERVICES

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

1. Bed and Board

   Bed, board, and general nursing service in:

   a. a room with two or more beds;

   b. a private room (private room allowance is equal to the most prevalent semiprivate room charges of your Hospital). Private room charges in excess of the semiprivate room allowance will not be eligible for Benefits unless the patient is required under the infection control policy of the Hospital to be in isolation to prevent contagion;

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

   Inpatient services are subject to the Precertification guidelines of this Contract. If you fail to comply with these guidelines, Benefits for Covered Services rendered during your Inpatient confinement will be reduced by $500.

2. Ancillary Services

   a. operating, delivery and treatment rooms;

   b. prescribed drugs;

   c. whole blood, blood processing and administration;

   d. anesthesia supplies and services rendered by an employee of the Hospital or other Provider;

   e. medical and surgical dressings, supplies, casts, and splints;

   f. oxygen;

   g. subdermally implanted devices or appliances necessary for the improvement of physiological function;

   h. Diagnostic Services;

   i. Therapy Services.

      Benefits for Speech Therapy are limited to Inpatient services only.

3. Emergency Accident Care

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

4. Emergency Medical Care

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

5. Surgery

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

6. Routine Nursery Care

   a. Inpatient Hospital Services for Routine Nursery Care of an infant born to a Member or Subscriber spouse, provided:

      1) the Member's coverage has been in effect for 365 days before the date the Covered Services are Incurred; and

      2) the newborn is a covered Dependent under this Contract.

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

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

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

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

B. **SURGICAL/MEDICAL SERVICES**

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

1. Surgery

   a. Payment includes visits before and after Surgery.

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

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

         a) the primary procedure; plus

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

      3) Sterilization, regardless of Medical Necessity.

   b. Assistant Surgeon

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

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

c. Anesthesia

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

2. Inpatient Medical Services

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

a. Inpatient Medical Care Visits

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

b. Intensive Medical Care

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

c. Concurrent Care

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

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

d. 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.

e. Newborn Well Baby Care

The initial Inpatient visit to examine a newborn Subscriber.

3. Outpatient Medical Services

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

a. Emergency Accident Care

Treatment of accidental bodily injuries.

b. Emergency Medical Care

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

c. Home, Office and Other Outpatient Visits

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

d. Routine Gynecological Examination

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

e. Contraceptive Devices

Contraceptive devices which are:

1) placed or prescribed by a Physician;

2) intended primarily for the purpose of preventing human conception; and

3) approved by the U. S. Food and Drug Administration as acceptable methods of contraception.

f. Prostate Cancer Screening

Annual screening for the early detection of prostate cancer in male Subscribers age 40 or older, including a prostate-specific antigen blood test and a digital rectal examination. **Benefits are limited to one screening exam per Benefit Period and shall not exceed $65 per screening.**

g. Immunizations, limited to:

1) Diphtheria, tetanus, and pertussis (whooping cough) vaccine (DTaP);

2) Tetanus vaccine;

3) Poliomyelitis vaccine;

4) Measles virus vaccine;

5) Mumps virus vaccine;

6) German measles (rubella) vaccine;

7) Measles, mumps, and rubella vaccine (MMR);

8) Varicella (chicken pox) vaccine;

9) Pneumonia vaccine;

10) Pneumococcal conjugate vaccine;

11) Haemophilus influenzae Type b (Hib);

12) Hepatitis A and hepatitis B vaccine, **limited to Subscribers under age 19.**

h. Child Health Supervision Services

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

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

1) Up to six reviews in the first year following the child's birth;

2) Up to two reviews for children between the ages of one and two;

3) One review each year for children ages three through six; and

4) One review every two years for children ages seven through 18.

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

i. Bone Density Testing

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

j. Diabetes Treatment

Equipment, supplies and related services for the treatment of Type I, Type II, and gestational diabetes when Medically Necessary and when recommended or prescribed by a Physician or other Provider. Diabetes treatment, including self-management training, must be conducted in accordance with the standards developed by the Oklahoma State Board of Health.

C. **OUTPATIENT DIAGNOSTIC SERVICES**

1. Radiology, Ultrasound and Nuclear Medicine

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

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

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

Benefits for *routine* Low-Dose Mammography are limited to $115 per screening.

2. Laboratory and Pathology

3. ECG, EEG, and Other Electronic Diagnostic Medical Procedures and Physiological Medical Testing, as determined by the Plan

D. **OUTPATIENT THERAPY SERVICES**

1. Radiation Therapy

2. Chemotherapy

3. Respiratory Therapy

4. Dialysis Treatment

5. Physical Therapy and Occupational Therapy

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

E. **MATERNITY SERVICES**

Hospital Services and Surgical/Medical Services from a Provider (not including the services of midwives) to a Member or Subscriber spouse for:

1. Normal Pregnancy

Normal pregnancy includes any condition usually associated with pregnancy, but not considered a complication of pregnancy as listed below.

Benefits for normal pregnancy are available for the Member or Subscriber spouse, provided a membership including Maternity Services has been in effect continuously for a period which shall be the lesser of the following:

a. the remainder of the waiting period applicable under the Subscriber's coverage in effect immediately preceding the Effective Date under this Contract; or

b. 365 days before the date the Covered Services are Incurred.

The 365-day waiting period for Maternity Services will be ***waived*** for a Subscriber who, at the time of enrollment under this Contract, was enrolled under the Blue Cross and Blue Shield Federal Employees Program.

2. Complications of Pregnancy

   a. Complications of pregnancy are conditions requiring Medical Care, Hospital confinement, or Outpatient Surgery, where the diagnosis is distinct from pregnancy, but which may be adversely affected by pregnancy or caused by pregnancy.

      Complications of pregnancy covered under this Contract are limited to the following:

      1) Extrauterine pregnancy;

      2) Hyperemesis gravidarum (persistent, severe vomiting of pregnancy);

      3) Toxemia with convulsions;

      4) Miscarriage or non-elective abortion occurring earlier than the 28th week of a pregnancy;

      5) Acute nephritis, nephrosis, cardiac decompensation or missed abortion;

      6) Non-elective cesarean section or spontaneous termination of pregnancy, which occurs during the period of gestation in which a viable birth is not possible;

      7) Other conditions requiring intra-abdominal Surgery after termination of pregnancy.

   b. Complications of pregnancy shall not include:

      1) False labor;

      2) Occasional spotting;

      3) Physician prescribed rest during the period of pregnancy; or

      4) Morning sickness.

   c. Hospital Services and Surgical/Medical Services related to the Subscriber's labor and delivery, by cesarean section or vaginal delivery, will not be covered unless the Subscriber has satisfied the maternity waiting period specified in this Contract, although labor and delivery may result in successful treatment of the complication of pregnancy.

3. Covered Maternity Services shall include:

   a. A minimum of 48 hours of Inpatient care at a Hospital, or a birthing center licensed as a Hospital, following a vaginal delivery for the mother and newborn infant who are covered under this Contract after childbirth, except as otherwise provided in this section; or

   b. A minimum of 96 hours of Inpatient care at a Hospital following a delivery by cesarean section for the mother and newborn infant who are covered under this Contract after childbirth, except as otherwise provided in this section; and

   c. Postpartum home care following a vaginal delivery if childbirth occurs at home or in a birthing center licensed as a birthing center. The coverage shall provide for one home visit within 48 hours of childbirth by a licensed health care Provider whose scope of practice includes providing postpartum care. The visits shall include, at a minimum:

      1) physical assessment of the mother and newborn infant;

      2) parent education regarding childhood immunizations;

      3) training or assistance with breast or bottle feeding; and

4) performance of any Medically Necessary and appropriate clinical tests.

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

4. Inpatient care shall include, at a minimum:

a. physical assessment of the mother and newborn infant;

b. parent education regarding childhood immunizations;

c. training or assistance with breast or bottle feeding; and

d. performance of any Medically Necessary and appropriate clinical tests.

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

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

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

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

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

4) the availability of postdischarge follow-up to verify the condition of the newborn infant in the first 48 hours after delivery; and

b. 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:

1) physical assessment of the mother and newborn infant;

2) parent education regarding childhood immunizations;

3) training or assistance with breast or bottle feeding; and

4) performance of any Medically Necessary and appropriate clinical tests.

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

Maternity Services for Dependent children are not covered.

F. MASTECTOMY AND RECONSTRUCTIVE SURGICAL SERVICES

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

1. Inpatient Hospital Services for:

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

b. 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.

2. 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:

   a. reconstruction of the breast on which the mastectomy has been performed;

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

   c. prostheses and physical complications at all stages of mastectomy, including lymphedemas.

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

G. **HUMAN ORGAN AND TISSUE TRANSPLANT SERVICES**

1. Hospital and Surgical/Medical Services from a Provider for:

   a. Musculoskeletal transplants;

   b. Parathyroid transplants;

   c. Cornea transplants;

   d. Heart-valve transplants;

   e. Kidney transplants.

   f. Hospital Services and Surgical/Medical Services rendered by a Hospital, Physician, or other Provider for bone marrow transplants and/or stem cell rescue, liver transplants, heart transplants, lung transplants, or heart/lung transplants subject to the following special provisions:

   g. ***The Subscriber must receive Precertification from the Plan in order for Benefits to be provided under this Contract.*** The Plan has the sole and final authority for approving or declining requests for Precertification. This decision is based upon the Plan's review of supporting documents submitted by the attending Physician, on forms provided by the Plan, stating the diagnosis, the recommended course of treatment, and the name of the facility in which the transplant will be performed.

      1) Precertification will be considered for a heart transplant, provided the Subscriber:

         a) has terminal heart disease with an estimated life expectancy of less than six months; and

         b) has normal liver and kidney function; and

         c) has no serious concurrent systemic diseases, including but not limited to: sepsis, neoplasm, Type I diabetes, collagen vascular or auto-immune disease, major neurologic disorders, Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) infection; and

         d) is psychosocially stable and has a supportive social milieu.

      2) Precertification will be considered for a single-lung transplant, double-lung transplant, or heart/lung transplant, provided the Subscriber:

a) has end-stage cardiopulmonary or pulmonary disease with a life expectancy of 18 months or less; and

b) is not currently on mechanical ventilation; and

c) has no serious concurrent systemic diseases, including but not limited to: sepsis, neoplasm, Type I diabetes, collagen vascular or auto-immune disease, major neurologic disorders, Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) infection; and

d) has no concurrent use of systemic steroids; and

e) has normal liver and kidney function; and

f) has no previous major cardio-thoracic Surgery; and

g) is psychosocially stable and has a supportive social milieu.

3) Precertification will be considered for a liver transplant, provided the Subscriber:

a) has end-stage liver disease with a life expectancy of less than six months due to any of the following conditions:

i) Extra hepatic biliary atresia;

ii) Primary biliary cirrhosis;

iii) Primary sclerosing cholangitis;

iv) Antigen-negative hepatitis B;

v) Antigen-negative or antigen positive hepatitis C;

vi) Hepatic vein thrombosis (Budd-Chiari syndrome);

vii) Certain inborn errors of metabolism (such as Alpha-1-antitrypsin deficiency, Wilson's disease, and primary hemochromatosis); and

b) has normal kidney function; and

c) has no serious concurrent systemic diseases, including but not limited to: sepsis, neoplasm, Type I diabetes, collagen vascular or auto-immune disease, major neurologic disorders, Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) infection; and

d) is psychosocially stable and has a supportive social milieu.

No Benefits will be provided for a Subscriber with end-stage liver disease as a result of viral hepatitis where the Subscriber remains antigen positive (except for hepatitis C); or for a Subscriber whose primary cause of liver damage is secondary to alcohol abuse, unless it can be demonstrated that the Subscriber has abstained from alcohol for a period of no less than 24 months.

4) Precertification will be considered for an allogeneic or syngeneic bone marrow transplant (a transplant with a donor other than the patient) and/or stem cell rescue, with or without high-dose Chemotherapy and/or Radiation Therapy, only in the following cases:

a) There is a six out of six major histocompatibility complex antigen match between the patient and the donor; and

b) One of the following conditions is being treated:

i) Aplastic anemia;

ii) Acute leukemia;

iii) Stage IV intermediate or high-grade lymphoma with bone marrow involvement;

iv) Severe combined immunodeficiency;

v) Wiskott-Aldrich syndrome;

vi) Infantile malignant osteopetrosis;

vii) Chronic myelogenous leukemia;

viii) Stage III or IV neuroblastoma in children over one year of age;

ix) Thalassemia major.

5) Precertification will be denied, *and Benefits will not be provided*, for any other allogeneic or syngeneic bone marrow transplants and/or stem cell rescue (or for high-dose Chemotherapy or Radiation Therapy performed in conjunction with such transplants), such as:

a) Cases in which five out of six or fewer major histocompatibility complex antigens match;

b) Polycythemia vera;

c) Intermediate or high-grade lymphoma other than Stage IV with bone marrow involvement;

d) Multiple myeloma;

e) Acquired Immunodeficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV) infection.

6) Precertification will be considered for an autologous bone marrow transplant and/or stem cell rescue (in which the patient is the donor), with high-dose Chemotherapy or Radiation Therapy, only for the following conditions:

a) Breast cancer;

b) Stage III or IV Hodgkin's disease which has come back after an initial complete remission, with no bone marrow involvement;

c) Stage III or IV intermediate or high-grade non-Hodgkin's lymphoma which has come back after an initial complete remission, with no bone marrow involvement;

d) Stage III or IV neuroblastoma, without bone marrow involvement;

e) Acute lymphocytic or non-lymphocytic leukemia which has come back after an initial complete remission;

f) Acute myeloblastic leukemia in first remission, with chromosome 5 and/or 7 abnormalities documented on cytogenetics;

g) Multiple myeloma; except that only a single transplant/stem cell rescue will be allowed. No Benefits will be available for a second procedure or for tandem transplantation.

7) Precertification will be denied, *and Benefits will not be provided*, for autologous bone marrow transplants, stem cell rescue, or high-dose Chemotherapy or Radiation Therapy for any other cases, such as:

a) Acute leukemia in first remission;

b) Hodgkin's or non-Hodgkin's lymphoma in first remission;

c) Intrinsic brain tumors;

d) Ovarian cancer;

e) Lung cancer;

f) Testicular cancer;

g) Colon cancer;

h) Wilms' tumor;

i) Acquired Immunodeficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV) infection.

h. The transplant must meet the criteria established by the Plan for assessing and performing human bone marrow transplants and/or stem cell rescue, liver transplants, heart transplants, lung transplants, or heart/lung transplants.

i. 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 human bone marrow transplants and/or stem cell rescue, liver transplants, heart transplants, lung transplants, or heart/lung transplants.

j. **Benefits for Organ Procurement Services will not exceed $15,000 for each liver, heart, lung, or heart/lung transplant performed.**

2. Benefits are not provided for any of the following:

a. Any services which the Plan considers to be Experimental or Investigational in nature. These include, but are not limited to:

1) Intestinal transplants;

2) Adrenal to brain transplants;

3) Islet cell transplants;

4) Pancreas transplants, except:

a) when performed simultaneously with a kidney transplant for a Subscriber who is a Severe Type I Diabetic and who would otherwise be considered a suitable candidate for a kidney transplant; and

b) when the Subscriber has obtained Precertification for such transplant.

No Benefits will be provided for a pancreas transplant which is not performed in conjunction with a kidney transplant, or which is performed *after* the Subscriber has received a kidney transplant.

b. More than one organ or tissue (including bone marrow and/or stem cell) of the same type, with the exception of a double-lung transplant done at one time. For the purposes of this Contract, a heart-only, lung-only, or heart/lung transplant will be considered the same type organ.

c. Any organ or tissue transplant from a non-human donor or for the use of non-human organs for extracorporeal support and/or maintenance.

d. Any artificial device for transplantation/implantation, including, but not limited to an artificial or mechanical heart, lung, liver, or pancreas.

e. Any organ or tissue transplant procedure which is not specifically listed as a Covered Service in this Contract.

3. If a human organ or tissue transplant is provided from a *living* donor to a human transplant recipient:

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

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

c. When only the donor is a Subscriber, the donor is entitled to the Benefits of this Contract. The Benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage or other Blue Cross or Blue Shield coverage or any government program available to the recipient. No Benefits will be provided to the non-Subscriber transplant recipient.

d. If any organ or tissue is sold rather than donated to the Subscriber recipient, no Benefits will be payable for the purchase price of such organ or tissue. However, other costs related to evaluation and procurement are covered up to the Subscriber recipient's Contract limit.

e. **Donor Benefits for bone marrow transplants and/or stem cell rescue are limited to Covered Services Incurred by the Subscriber recipient's blood-related family members only.**

H. AMBULATORY SURGICAL FACILITY SERVICES

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

1. such services are Medically Necessary;

2. an operative or cutting procedure which cannot be done in a Physician's office is actually performed; and

3. the operative or cutting procedure is a Covered Service under this Contract.

I. PSYCHIATRIC CARE SERVICES

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

1. Inpatient Facility Services

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

2. Inpatient Medical Services

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

a. Medical Care visits **limited to one visit or other service per day.**

b. Individual Psychotherapy

c. Group Psychotherapy

d. Psychological Testing

e. Convulsive Therapy Treatment

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

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

3. Outpatient Psychiatric Care Services

a. Facility and Medical Services

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

b. Day/Night Psychiatric Care Services

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

Outpatient Convulsive Therapy Treatment is excluded.

4. Drug Abuse and Alcoholism

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

Your Benefits for Psychiatric Care Services will not exceed:

- **30 days' Inpatient Psychiatric Care Services per Benefit Period per Subscriber.**
- **$1,000 per Benefit Period per Subscriber for Outpatient Psychiatric Care Services.**
- **$25,000 per *lifetime* per Subscriber for combined Inpatient and Outpatient Psychiatric Care Services.**

J. **AMBULANCE SERVICES**

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

a. from your home to a Hospital;

b. from the scene of accident or medical emergency to a Hospital;

c. between Hospitals;

d. between a Hospital and Skilled Nursing Facility;

e. from the Hospital to your home.

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

K.

L. **PRIVATE DUTY NURSING SERVICES**

Services of a practicing RN, LPN or LVN when ordered by a Physician and when Medically Necessary.

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

M. **REHABILITATION CARE**

1. Inpatient Hospital Services, including Physical Therapy, Speech Therapy and Occupational Therapy, provided by the rehabilitation department of a Hospital, or other Plan-approved rehabilitation facility, after the acute care stage of an illness or injury.
2. **Rehabilitation Care is limited to 30 days of Inpatient care per Benefit Period per Subscriber.**
3. **Rehabilitation Care is subject to the Precertification guidelines of this Contract. Failure to comply with these guidelines will result in a $500 reduction in Benefits for Rehabilitation Care.**

N. **SKILLED NURSING FACILITY SERVICES**

1. Covered Inpatient Hospital Services and supplies given to an Inpatient of a Plan-approved Skilled Nursing Facility.
2. **Skilled Nursing Facility Services are limited to 30 days of Inpatient care per Benefit Period per Subscriber.**
3. **Skilled Nursing Facility Services are subject to the Precertification guidelines of this Contract. Failure to comply with these guidelines will result in a $500 reduction in Benefits for Skilled Nursing Facility Services.**
4. No Benefits are payable:
   a. once you can no longer improve from treatment; or
   b. for Custodial Care, or care for someone's convenience.

O. **HOME HEALTH CARE SERVICES**

1. We pay the scheduled amounts for the following Covered Services you receive from a Hospital program for Home Health Care or Community Home Health Care Agency, provided such program or agency is a Plan-approved Provider and the care is prescribed by a Physician:
   a. Medical and surgical supplies;
   b. Prescribed drugs;
   c. Oxygen and its administration;
   d. **Up to 30 visits per Benefit Period per Subscriber, limited to the following:**
      1) Professional services of an RN, LPN, or LVN;
      2) Medical social service consultations;
      3) Health aide services while you are receiving covered nursing or Therapy Services.
2. **Home Health Care Services are subject to the Precertification guidelines of this Contract. Failure to comply with these guidelines will result in a $500 reduction in Benefits for Home Health Care.**
3. We do not pay Home Health Care Benefits for:
   a. Dietitian services;

b. Homemaker services;

c. Maintenance therapy;

d. Physical Therapy, Speech Therapy or Occupational Therapy;

e. Durable Medical Equipment;

f. Food or home-delivered meals;

g. Intravenous drug, fluid, or nutritional therapy, **except when you have received Precertification from the Plan for these services.**

P. **HOSPICE SERVICES**

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

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

3. **Hospice Services are subject to the Precertification guidelines of this Contract. Failure to comply with these guidelines will result in a $500 reduction in Benefits for Hospice Services.**

Q. **DENTAL SERVICES RELATED TO ACCIDENTAL INJURY**

Dental services for accidental injury to the jaws, sound natural teeth, mouth or face that occurs on or after your Effective Date. 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.

R. **PRESCRIPTION DRUGS**

Insulin, Prescription Drugs (including oral contraceptive medications), and medications compounded by a pharmacist which contain a Prescription Drug. Prescription Drugs prescribed and used for cosmetic purposes are not covered.

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

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

S. **DURABLE MEDICAL EQUIPMENT**

The rental (or, at the Plan's option, purchase, if it will be less expensive) of Durable Medical Equipment (such as respirators and oxygen tents) including replacement, repair and adjustment of purchased equipment, provided such equipment is prescribed by a Physician and Medically Necessary for the Subscriber's therapeutic use. Also covered are wheelchairs, hospital beds, crutches, and other items determined by the Plan to be Durable Medical Equipment, but not including disposable items or supplies.

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

T. **PROSTHETIC APPLIANCES**

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

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

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

U. **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 of your previous level of daily living activity. **Benefits for replacement of such devices will be provided only when Medically Necessary due to changes in the size of the body part being supported.**

Benefits will be provided for the following orthotic devices:

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

Not covered are:

1. Arch supports and other foot support devices;
2. Elastic stockings;
3. Garter belts or similar devices;
4. Orthopedic shoes.

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

SECTION VI — EXCLUSIONS

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

A. **PREEXISTING CONDITION LIMITATION**

1. Benefits will not be provided for a Preexisting Condition, or for charges relating to a Preexisting Condition, until the date the Subscriber's coverage has been in effect for 12 consecutive months. However, in the case of a Subscriber who at the time of enrollment under this Contract was enrolled in any coverage underwritten by Blue Cross and Blue Shield of Oklahoma, and such Subscriber had been subject to any Preexisting Condition limitation under such prior coverage, then said Subscriber shall be required to complete only the portion of the Preexisting Condition waiting period remaining, not to exceed a period of 12 consecutive months following the Subscriber's Effective Date under this Contract.
2. In addition, the 12-month waiting period for Preexisting Conditions will be ***waived*** for a Subscriber who, at the time of enrollment under this Contract, was enrolled in any coverage issued under another Blue Cross and/or Blue Shield Plan's names and service marks or enrolled under the Blue Cross and Blue Shield Federal Employees Program.

B. Some limitations are spelled out in other parts of this Contract. In addition to those limitations, no Benefits will be provided for services, supplies or charges:

1. Which are not prescribed by or performed by or upon the direction of a Physician or other Provider.
2. Which we determine are not Medically Necessary, except as specified.
3. Received from other than a Provider.
4. Which are in excess of the Allowable Charge, as determined by the Plan.
5. Which the Plan determines are Experimental/Investigational in nature.
6. For any illness or injury occurring in the course of employment if whole or partial compensation or Benefits are or might have been available under the laws of any governmental unit; any policy of workers' compensation insurance; or according to any recognized legal remedy arising from an employer-employee relationship. This applies whether or not you claim the Benefits or compensation or recover the losses from a third party.
    a. You agree to:
        1) pursue your rights under the workers' compensation laws;
        2) take no action prejudicing the rights and interests of the Plan; and
        3) cooperate and furnish information and assistance the Plan requires to help enforce its rights.
    b. 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:
        1) hold 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
        2) repay the Plan any money recovered from your employer or insurance carrier.
7. To the extent payment has been made under Medicare or would have been made if you had applied for Medicare and claimed Medicare benefits, or to the extent governmental units provide Benefits (some state or federal laws may affect how we apply this exclusion).

8. For illness or injury that occurs after your Effective Date as a result of any act of war.
9. For which you have no legal obligation to pay in the absence of this or like coverage.
10. 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.
11. For cosmetic Surgery or complications resulting therefrom, including Surgery to improve or restore your appearance, unless:
    a. needed to repair conditions resulting from an accidental injury which occurs after your Effective Date; or
    b. for the improvement of the physiological functioning of a malformed body member, except for services related to Orthognathic Surgery, osteotomy, or any other form of oral Surgery, dentistry, or dental processes to the teeth and surrounding tissue.

    In no event will any care and services for breast reconstruction or implantation or removal of breast prostheses be a Covered Service unless such care and services are performed solely and directly as a result of mastectomy which is Medically Necessary.
12. Received from a member of your immediate family.
13. Received before your Effective Date.
14. For any Inpatient care and services, including rehabilitation care and services, unless documentation can be provided that, due to the nature of the services rendered or your condition, you cannot receive safe or adequate care as an Outpatient.
15. Received after your coverage stops.
16. For personal hygiene and convenience items regardless of whether or not recommended by a Physician or other Provider. Examples include: air conditioners, air purifiers or filters; humidifiers; or physical fitness equipment, including exercise bicycles or treadmills.
17. For telephone consultations, missed appointments, or completion of a claim form.
18. For Custodial Care such as sitters' or homemakers' services, care in a place that serves you primarily as a residence when you do not require skilled nursing, or for rest cures.
19. 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.
20. For routine or periodic physical examinations.
21. For screening examinations, including x-ray examinations made without film.
22. Resulting from attempted suicide or intentionally self-inflicted injury or illness.
23. For reverse sterilization.
24. For contraceptive medications or devices which are sold without a Physician's prescription (including condoms; contraceptive foam, sponges, or cream; or other spermicides).
25. 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:
    a. the treatment of accidental injury to the jaw, sound natural teeth, mouth or face occurring on or after the Subscriber's Effective Date; or
    b. for the improvement of the physiological functioning of a malformed body member.

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

26. 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:

    a. severely disabled; or

    b. eight years of age or under;

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

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

28. For eye Surgery such as radial keratotomy, laser correction or any other procedure, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).

29. For hearing aids, tinnitus masters, or examinations for prescribing or fitting them. 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.

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

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

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

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

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

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

36. For conditions related to autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems, mental retardation, or for Inpatient confinement for environmental change.

37. For which the Provider of service customarily makes no direct charge to a Subscriber.

38. Received from a Skilled Nursing Facility, Home Health Care Agency, Hospice, or rehabilitation facility which is not a Plan-approved Provider.

39. 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.

40. For or related to transplantation of donor organs or tissues other than musculoskeletal, parathyroid, cornea, heart-valve, kidney, kidney/pancreas, bone marrow and/or stem cell, liver, heart, lung or heart/lung when performed by or under the auspices of a Plan-approved transplant program.

41. For Physician standby services.

42. Which are not specifically named as Covered Services subject to any other specific Exclusions and limitations in your Contract.

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

SECTION VII — DUES

This section explains the Dues which you must pay for your coverage, how those payments are made, and what happens if you fail to pay your Dues.

A. **AMOUNT OF DUES**

Your Dues are determined by the Plan, based upon the Benefits provided in this Contract. This amount is set forth in the periodic Member billing notice and is filed with the Insurance Commissioner of the State of Oklahoma.

B. **CHANGES IN CARE AND SERVICES OR DUES**

The Plan may change Dues upon 31 days' written notice to the Member, or when the Contract Benefits are changed by Amendment or Endorsement.

C. **PAYMENT OF DUES**

YOUR DUES ARE PAYABLE BY YOU DIRECTLY TO THE PLAN AND MUST BE PAID ON OR BEFORE THE EFFECTIVE DATE SHOWN ON YOUR IDENTIFICATION CARD. ALL FURTHER DUES ARE PAYABLE IN ADVANCE OF AND NO LATER THAN THE DUE DATE SHOWN ON THE MEMBER BILLING NOTICE.

D. **NON-PAYMENT OF DUES**

If you fail to pay your Dues or other payment to the Plan on or before the due date, this Contract will automatically, and without notice, be terminated and cancelled on your “paid-to-date” of coverage. The Plan reserves the sole right to reinstate this Contract after its termination and cancellation for non-payment of Dues upon the terms and conditions it determines to be acceptable.

SECTION VIII — GENERAL PROVISIONS

This section tells how your coverage works. It shows you such things as:

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

A. ENTIRE CONTRACT; CHANGES

This Contract, with the application and the Identification Card, is the entire Contract between you and the Plan. No change in this Contract will be effective until approved by an authorized Plan officer. This approval must be noted on or attached to this Contract. No agent or representative of the Plan other than a Plan officer may otherwise change this Contract or waive any of its provisions. All statements made by the Subscriber or by any individual Member shall, in the absence of fraud, be deemed representations and not warranties.

B. BENEFITS TO WHICH YOU ARE ENTITLED

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

C. PRIOR APPROVAL

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

D. RECORDS OF SUBSCRIBER ELIGIBILITY AND CHANGES IN SUBSCRIBER ELIGIBILITY

1. The Member must furnish the Plan with any data required by the Plan for coverage of Subscribers under this Contract.
2. All notification by the Member to the Plan must be furnished on forms approved by the Plan. The notification must include all information reasonably required by the Plan to effect changes.

E. GUARANTEED RENEWABILITY OF COVERAGE

Coverage under this Contract will continue in force at the option of the Member. However, the Plan may nonrenew or discontinue coverage of a Member and his/her Dependents for the following reasons:

1. non-payment of Dues,
2. fraud;
3. termination of the particular type of coverage, or all coverage, in the individual market; or
4. movement of the Member and/or his/her Dependents outside the Plan's service area

F. TERMINATION OF A SUBSCRIBER'S COVERAGE UNDER THIS CONTRACT

1. When a Subscriber ceases to be an Eligible Person or Eligible Dependent, coverage will end on the last day of the coverage period for which payment of Dues has been made, except that:

   a. When a Subscriber ceases to be an Eligible Dependent by reason of divorce, coverage for that Subscriber will cease on the date the divorce is granted.

   b. When a Subscriber ceases to be an Eligible Dependent child because he/she has married, coverage for that Subscriber will cease on the marriage date.

   c. When a Subscriber ceases to be an Eligible Dependent child by reason of attaining the limiting age for Dependent children, unless medically certified as Totally Disabled, coverage for that Subscriber will cease on the January 1st following the year during which the child attains such limiting age.

2. If applicable, payment made for coverage beyond the termination date specified above will be refunded to you.

3. A Member's coverage (including coverage for his or her Dependents, if any) shall be terminated retroactive to the Effective Date if the Member commits fraud or material misrepresentation in applying for or obtaining coverage under this Contract. A Subscriber's coverage shall terminate immediately if he or she files a fraudulent claim.

4. In the event the required Dues are not paid for your coverage under this Contract, your coverage will stop at the end of the coverage period for which payment of Dues has been made.

G. BENEFITS AFTER TERMINATION OF COVERAGE

1. If your coverage terminates for any reason, Benefits under this Contract shall cease as of the Effective Date and time of such termination. However, such termination of coverage will not deprive you of Benefits to which you would otherwise be entitled for Covered Services Incurred during a Hospital confinement which began before the date and time of termination. Benefits will be provided only for the lesser of:

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

   b. the duration of the Hospital confinement; or

   c. a period of 90 days following termination of coverage.

2. The Plan will have no liability for any Benefits under this Contract for Covered Services Incurred after your coverage terminates, except as specified above.

H. TRANSFER PRIVILEGES

1. If a Subscriber ceases to be eligible under this Contract, he/she may apply for continuous coverage under an Individual Conversion Contract in his/her own name, subject to the applicable underwriting and enrollment regulations. Written application for the coverage must be received by the Plan within 31 days after the Subscriber ceases to be eligible under this Contract. If the application is approved, the new Contract will be effective on the date of termination of the Subscriber's coverage under this Contract. Direct payment for the coverage must be made from the date the person ceases to be covered under this Contract.

2. When you reach age 65, you may transfer coverage to the Plan's Medicare supplement program, Plan 65. You may apply for Plan 65 coverage any time before your 66th birthday. However, if you apply within 31 days of termination from this Contract, your coverage will be continuous. Your spouse and your Dependent children, if any, may continue coverage under an Individual Conversion Contract in their name. When your spouse reaches age 65, he/she may also apply for Plan 65 coverage.

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 65th birthday.

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

4. A Subscriber will not be eligible to transfer coverage to a membership in his/her own name if he/she ceases to be eligible under this Contract because of:

   a. non-payment of Dues, or

   b. fraud or material misrepresentation made in any statement, application, health statement, claim or other forms submitted to obtain this Contract or any of its Benefits.

I. NOTICE AND PROOF OF LOSS

1. The Plan will not be liable under the Contract unless proper notice is furnished to the Plan that Covered Services have been rendered to you. Upon receipt of written notice, the Plan will furnish claim forms to you for filing Proof of Loss. If the forms are not furnished within 15 days after the Plan receives your notice, you may comply with the Proof of Loss 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.

2. Your claim form or other Proof of Loss must be furnished to the Plan within 90 days after the date you receive Covered Services.

3. Failure to give Proof of Loss to the Plan within the time specified will not reduce your Benefits if you show that the proof was given as soon as reasonable possible.

J. RELEASE OF INFORMATION

You agree that we may request, and anyone may give to us, any information (including copies of records) about your illness or injury for which Benefits are claimed. Also, that we may give similar information, if requested, to anyone providing similar Benefits to you.

K. LIMITATION OF ACTIONS

No legal action may be taken to recover Benefits within 60 days after Proof of Loss has been given. No such action may be taken later than two years after expiration of the time within which Proof of Loss is required by the Contract.

L. PAYMENT OF BENEFITS

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

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

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

4. For Covered Services provided to you under this Contract, Benefits will be based upon the Allowable Charge (as we determine) for Covered Services. However, if you receive Covered Services from an Out-of-Network Provider, you may be responsible for amounts which exceed the Allowable Charge, in addition to the Deductible and/or Coinsurance amounts.

5. In some cases, Covered Services may be rendered by a Provider who has a Participating Provider Agreement (*other than a BlueChoice PPO Provider Agreement*) with the Plan. These Providers (*called BlueTraditional Providers*) have agreed to charge Plan Subscribers no more than a "Maximum Reimbursement Allowance" for Covered Services. Subscribers who use BlueTraditional Providers are responsible for amounts over the "Allowable Charge", *up to but not exceeding* the Maximum Reimbursement Allowance specified in the Provider's Participating Provider Agreement.

M. DETERMINATION OF BENEFITS AND UTILIZATION REVIEW

1. The Plan, as claims administrator, is hereby granted discretionary authority to interpret the terms and conditions of the Contract and to determine its Benefits. Such determination by the Plan as to whether care and services you receive are eligible for Benefits under the Contract may be made by a panel of Physicians appointed by the Plan at its election.

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

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

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

   a. you arrange for medical records to be provided to the Plan; and/or

   b. you submit to a professional evaluation by a Provider selected by the Plan, at the Plan's expense; and/or

   c. a Physician consultant or panel of Physicians or other Providers appointed by the Plan review the claim.

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

N. SUBSCRIBER/PROVIDER RELATIONSHIP

1. The choice of a Provider is solely yours.

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

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

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

O. APPLICABLE LAW

This Contract is entered into in and is subject to the laws of the State of Oklahoma.

P. SUBSCRIBER RIGHTS

You have no rights or privileges except as specifically provided in this Contract.

Q. NOTICE

Any notice required under this Contract must be in writing. Notice given to the Plan must be sent:

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

Notice given to you will be sent to your address as it appears on the Plan's records. You or the Plan may, by written notice, indicate a new address for giving notice.

R. COORDINATION OF BENEFITS

All Benefits provided under the Contract are subject to this provision and will not be increased because of this provision:

1. Definitions

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

"*Program*" means any arrangement providing health care Benefits or services through coverage under any tax supported or government program, including Medicare, except where state or federal law requires this Contract to reimburse for or to pay before the benefits of such tax supported or government program. However, in no event will the Benefits of this Contract paid because of such law exceed the lesser of the benefits required to be paid by such law and the Benefits available under this Contract in the absence of such tax supported or government program.

"Program" shall be applied separately with respect to each arrangement for benefits or services and separately with respect to that portion of any arrangement which reserves the right to take the benefits or services of other Programs into consideration in determining its benefits and that portion which does not.

"*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 Program covering the person for whom claim is made or service provided. When Benefits are provided in the form of services, the reasonable cash value of each service shall be deemed the Benefit.

2. Effect On Benefits

This provision will apply in determining the Benefits of this Contract for any Calendar Year if, for the Covered Services received during that period, the sum of the Benefits payable under this Contract and the Benefits payable under other Programs would exceed the Covered Services.

The Benefits payable under this Contract for Covered Services received during a Calendar Year will be reduced so that the sum of the reduced Benefits and the Benefits payable for Covered Services under other Programs does not exceed the Allowable Charge for Covered Services. Benefits payable under other Programs include the Benefits that would have been payable had claim been made.

The rule establishing the order of Benefits when a person receives Covered Services under any other Program is: The benefits of the other Program, including Medicare, will be determined before the Benefits of this Contract and the Benefits of this Contract will be reduced to the extent set forth in the paragraph above.

3. **Facility Of Payment**

Whenever payments should have been made under this Contract in accordance with this provision, but the payments have been made under any other Program, the Plan has the right to pay to any organization that has made such payment any amount it determines to be warranted to satisfy the intent of this provision. Amounts so paid will be deemed to be Benefits paid under this Contract and, to the extent of the payments for Covered Services, the Plan will be fully discharged from liability under this Contract.

4. **Right Of Recovery**

a. Whenever payments have been made by the Plan for Covered Services in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, irrespective of to whom paid, the Plan will have the right to recover the excess from among the following, as the Plan will determine: any person to or for whom such payments were made, any insurance company, or any other organization.

b. The Member, personally and on behalf of family Subscribers shall, upon request, execute and deliver such documents as may be required and do whatever else is necessary to secure the Plan's rights to recover the excess payments.

c. This right of recovery is limited to 24 months after the payment is made, unless:

1) the payment was made because of fraud committed by the Subscriber or Provider; or

2) the Subscriber or Provider has otherwise agreed to make a refund to the Plan for overpayment of a claim.

S. **PLAN'S RIGHT OF RECOUPMENT**

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

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

3. 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.

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

T. PLAN/ASSOCIATION RELATIONSHIP

Each Member hereby expressly acknowledges his/her understanding that this Contract constitutes a Contract solely between the Member and the Plan, which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting the Plan to use the Blue Cross and Blue Shield Service Marks in the State of Oklahoma, and that the Plan is not contracting as the agent of the Association. The Member further acknowledges and agrees that he/she has not entered into this Contract based upon representations by any person other than the Plan and that no person, entity, or organization other than the Plan shall be held accountable or liable to the Member, or any Subscribers, for any of the Plan's obligations to the Member or Subscribers created under the Contract. This paragraph shall not create any additional obligations whatsoever on the part of the Plan other than those obligations created under other provisions of the Contract.

U. MEMBERS ANNUAL MEETING

The annual meeting of the Members of the Plan will be held on the third Wednesday of April of each year at 5:30 p.m. at the Plan's general office, 1215 South Boulder, Tulsa, Tulsa County, Oklahoma. No additional notice will be given.

SECTION IX — SUBSCRIBER RIGHTS

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

You have the right to:

1. confidentiality of health information;
2. receive Medically Necessary and appropriate care and service as defined in this Contract;
3. receive courteous and respectful care and services from Blue Cross and Blue Shield of Oklahoma employees and network Providers;
4. receive information in clear and understandable terms;
5. participate with your Provider in decision-making about your health care treatment;
6. refuse treatment; and
7. file complaints when dissatisfied with the care and treatment received.

SECTION X — COMPLAINT/GRIEVANCE PROCEDURE

Blue Cross and Blue Shield of Oklahoma has established the following process to ensure the timely and organized resolution of Subscriber dissatisfactions, Complaints, and/or Grievances.

A. LEVEL ONE – ADMINISTRATIVE REVIEW

This process is initiated when a phone call or written Complaint/Grievance is directed to the Customer Service Department. The concern must be submitted within 60 days from the date of the occurrence that caused the Complaint/Grievance to be filed.

The Complaint/Grievance will be resolved by the Customer Service Representative, or by the supervisor in the department, within 60 days. If a resolution cannot be achieved through administrative review, or if further information is needed in order to adequately resolve a Complaint/Grievance, the Subscriber is informed that a second level of appeal may be requested.

B. LEVEL TWO – MEMBER PARTICIPATION AND PROTECTION COMMITTEE REVIEW

Level two is initiated when a resolution of the Subscriber's Complaint/Grievance cannot be achieved through administrative review. The Subscriber may request, in writing, that the relevant files and supporting documentation (including any personal statements by the Subscriber) be reviewed by the Member Participation and Protection Committee. This request must be received by the Plan within 60 days following the date the Subscriber receives the determination of administrative review. The Complaint/Grievance should be addressed and mailed to:

Grievance Coordinator — Customer Service Department
Blue Cross and Blue Shield of Oklahoma
P. O. Box 3283
Tulsa, Oklahoma 74102-3283

The Committee will complete its review within 60 days following the receipt of the Complaint/Grievance. In unusual cases, the review may require an additional 60 days. A letter stating the decision of the Committee will be sent to the Subscriber by Certified Mail.

SECTION XI – CLAIMS FILING PROCEDURES

This section tells when Providers file claims for your. It also explains what procedures to follow when you must file your claim.

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

A. BLUECHOICE PPO AND BLUETRADITIONAL PROVIDERS

BlueChoice PPO and BlueTraditional Providers have agreed to submit claims directly to the Plan for you. When you receive Covered Services from a network Provider, simply show your Identification Card, and claims submission will be handled for you. If you must use a Provider who is not a member of the Plan's BlueChoice PPO or BlueTraditional networks, you should follow the guidelines below in submitting your claims.

REMEMBER...

To receive the maximum Benefits under your BlueChoice PPO program, you must receive treatment from the BlueChoice PPO Providers shown in your directory.

B. PRESCRIPTION DRUG CLAIMS

To be eligible for discounts on Prescription Drugs and automatic claims filing, always use Participating Pharmacies.

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

C. 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.

D. AMBULATORY SURGICAL FACILITY CLAIMS

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

E. PHYSICIAN AND OTHER PROVIDER CLAIMS

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

F. MEMBER-FILED CLAIMS

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

Be sure to fill out the claim form completely, sign it, and attach the Provider's itemized statement. **If you have a new address, be sure to check the appropriate box on the claim form to be sure you receive payment**. Send the completed form to:

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

It is important that all information requested on the claim form be given; otherwise, the claim form may be returned to you for additional information, which will delay payment.

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

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

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

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

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

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

G. DIRECT CLAIMS LINE

We have a direct line for claims and membership inquiries. You may call one of the following numbers between 9:00 a.m. and 4:30 p.m., Monday through Friday, whenever you have a question concerning a claim or your membership:

- In the Tulsa area: (918) 560-3535
- In the Oklahoma City area: (405) 841-9596
- All other areas: 1-800-94 BLUES (1-800-942-5837)

BlueCross BlueShield of Oklahoma

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

AMENDMENT RESPECTING COMPLAINT/APPEAL PROCEDURE

IT IS AGREED that the **Contract** to which this amendment is issued for attachment is amended as set forth below:

A. The **"Preauthorization"** or **"Preauthorization/Precertification"** provisions are amended so that the paragraph entitled "Precertification Requests Involving Urgent Care" is hereby deleted and replaced by the following:

- **Preauthorization Requests Involving Urgent Care**

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

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

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

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

B. The **"Concurrent Review" or "Concurrent Review and Case Management"** provisions are deleted in their entirety and replaced by the following:

CONCURRENT REVIEW

Whenever it is determined that Inpatient care or an ongoing course of treatment may no longer be Medically Necessary, you, your Provider or your authorized representative may submit a request to the Plan for continued services. If you, your Provider or your authorized representative requests to extend

care beyond the approved time limit and it is a Request Involving Urgent Care, the Plan will make a determination on the request/appeal as soon as possible (taking into account medical exigencies) but no later than 72 hours after it receives the initial request, or within 48 hours after it receives the missing information (if the initial request is incomplete).

C. AMENDMENT RESPECTING COMPLAINT/APPEAL PROCEDURE

The **"Complaint/Appeal Procedures"** currently reflected in Contract, or in any amendment attached thereto, are hereby deleted and restated as follows:

COMPLAINT/APPEAL PROCEDURE

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

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

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

CLAIM DETERMINATIONS

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

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

IF A CLAIM IS DENIED OR NOT PAID IN FULL

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

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

- The reasons for the determination;
- A reference to the Benefit provisions on which the determination is based, or the contractual, administrative or protocol for the determination;

- A description of additional information which may be necessary to perfect an appeal and an explanation of why such material is necessary;
- Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care Provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
- An explanation of our internal review/appeals and external review processes (and how to initiate a review/appeal or external review);
- In certain situations, a statement in non-English language(s) that the written notice of the claim denial and certain other Benefit information may be available (upon request) in such non-English language(s);
- In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by us;
- The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for Benefits;
- Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
- An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances, if the denial was based on medical necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;
- In the case of a denial of an Urgent Care Clinical Claim, a description of the expedited review procedure applicable to such claims. An urgent care claim decision may be provided orally, so long as a written notice is furnished to the claimant within 3 days of oral notification; and
- Contact information for applicable office of health insurance consumer assistance or ombudsman.

TIMING OF REQUIRED NOTICES AND EXTENSIONS

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

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

the service rendered or furnished, the date of service, the diagnosis, the claim charge, and any other information which we may request in connection with services rendered to you.

URGENT CARE CLAIMS*

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

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

PRE-SERVICE CLAIMS

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

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

POST-SERVICE CLAIMS

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

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

CLAIM APPEAL PROCEDURES

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

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

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

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

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

  Upon receipt of an expedited pre-service or concurrent clinical appeal, we will notify the party filing the appeal, as soon as possible, but no more than 24 hours after submission of the appeal, of all the

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

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

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

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

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

  – Within 180 days after you receive notice of a denial or partial denial, you may call or write to our Administrative Office. We will need to know the reasons why you do not agree with the denial or partial denial. Send your request to:

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

  – We will honor telephone requests for information. However, such inquiries will not constitute a request for review.

  – In support of your claim review, you have the option of presenting evidence and testimony to us. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of an Adverse Benefit Determination or at any time during the claim review process.

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

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

- ***Timing of Appeal Determinations***

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

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

- ***Notice of Appeal Determination***

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

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

EXTERNAL REVIEW RIGHTS

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

Oklahoma Insurance Department
3625 NW 56th Street
Oklahoma City, OK 73112-4511
Telephone: 1-800-522-0071 or 405-521-2828

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

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

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

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

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

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

President of Blue Cross and Blue Shield of Oklahoma

BlueCross BlueShield of Oklahoma

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

AMENDMENT RESPECTING PREMIUM REBATES, PREMIUM ABATEMENTS AND COST-SHARING

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

The *General Provisions* section of the Contract/Certificate is modified to add the following new subsection:

PREMIUM REBATES, PREMIUM ABATEMENTS AND COST-SHARING

a. Rebate. In the event federal or state law requires the Plan to rebate a portion of annual premiums paid, the Plan will directly provide any rebate owed Members or former Members to such persons in amounts as required by law.

b. Abatement. The Plan may from time to time determine to abate (in whole or in part) the premium due under this Contract/Certificate for particular period(s).

   Any abatement of premium by the Plan represents a determination by the Plan not to collect premium for the applicable period(s) and does not effect a reduction in the rates under this Contract/Certificate. An abatement for one period shall not constitute a precedent or create an expectation or right as to any abatement in any future period(s).

c. The Plan makes no representation or warranty that any rebate or abatement owed or provided is exempt from any federal, state, or local taxes (including any related notice, withholding or reporting requirements). It will be the obligation of each Member or former Member (if applicable) owed or provided a rebate or an abatement to determine the applicability of and comply with any applicable federal, state or local laws or regulations.

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

The provisions of this Amendment shall be in addition to (and do not take the place of) the other terms and conditions of the Contract/Certificate.

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

This amendment is effective on the Policy Year beginning January 1, 2012, or the effective date of the Contract or Certificate to which it is issued for attachment, whichever is later.

President of Blue Cross and Blue Shield of Oklahoma

BlueCross BlueShield
of Oklahoma

1215 South Boulder • P. O. Box 3283 • Tulsa, OK 74102-3283

AMENDMENTS TO THE PERSONAL BLUE CONTRACT

IT IS AGREED that the Personal Blue (Individual Conversion) Contract to which this amendment is issued for attachment is amended as set forth below:

A. **AMENDMENT RESPECTING POLICY YEAR**

The Contract is amended to include a Policy Year. Policy Year means the 12-month period beginning January 1 each year.

B. **AMENDMENT RESPECTING DEPENDENT ELIGIBILITY**

Wherever used in the Contract or Certificate, "Dependent child" means a natural child, a stepchild, an adopted child or child Placed for Adoption (including a child for whom the Member or spouse is a party in a legal action in which the adoption of the child is sought), under 26 years of age, regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status, eligibility for other coverage, or any combination of those factors. A child not listed above who is legally and financially dependent upon the Member or spouse is also considered a Dependent child under the Group Health Plan, provided proof of dependency is provided with the child's application.

A Dependent child who is medically certified as disabled and dependent upon the Member or his/her spouse is eligible to continue coverage beyond the limiting age, provided the disability began before the child attained the age of 26.

C. **AMENDMENT RESPECTING LIFETIME MAXIMUMS**

The Lifetime Maximum set forth in the Schedule of Benefits, or in any amendment or endorsement to the Contract, is hereby deleted. Coverage under the Contract shall not be subject to any ***dollar*** Lifetime Maximum, including the separate ***dollar*** Lifetime Maximum previously applicable for treatment of Psychiatric Care Services.

Blue Cross and Blue Shield of Oklahoma believes this coverage is a "grandfathered health plan" under the Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Contract may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on Benefits for any individual.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at P.O. Box 3236, Naperville, Illinois 60566-7236.

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

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

For Contracts in effect before March 23, 2010, this amendment is effective on January 1, 2011.

President of Blue Cross and Blue Shield of Oklahoma

BlueCross BlueShield
of Oklahoma

1215 South Boulder • P. O. Box 3283 • Tulsa, OK 74102-3283

AMENDMENTS RESPECTING ALLOWABLE CHARGE DETERMINATIONS FOR OUT-OF-NETWORK SERVICES

IT IS AGREED that the Group Contract, Individual Conversion Contract or Certificate of Benefits to which this amendment is issued for attachment is amended by the addition of the following provisions:

A. AMENDMENT RESPECTING ALLOWABLE CHARGE FOR NON-CONTRACTING PROVIDERS

The Contract/Certificate is amended to reflect the following method for determining the Allowable Charge for Providers who do not have a Participating Provider agreement with Blue Cross and Blue Shield of Oklahoma (Non-Contracting Providers).

The Allowable Charge for Non-Contracting Providers for Covered Services will be the lesser of:

1. the Provider's billed charges; or
2. the Plan's Non-Contracting Allowable Charge.

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

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

In the event the Non-Contracting Allowable Charge does not equate to the Non-Contracting Provider's billed charges, the Member will be responsible for the difference, along with any

applicable Copayment, Coinsurance and Deductible amount. This difference may be considerable. To find out an estimate of the Plan's Non-Contracting Allowable Charge for a particular service, Members may call the customer service number shown on the back of the Blue Cross and Blue Shield of Oklahoma Identification Card.

B. **AMENDMENT RESPECTING SERVICES RECEIVED OUTSIDE THE STATE OF OKLAHOMA**

The Contract/Certificate is amended to reflect the following provisions related to the processing of "Out-of-Network" or "Non-Participating" Provider claims:

Blue Cross and Blue Shield Plans in other states are now *required* to determine the "Allowable Charge" for services received outside the state of Oklahoma. Because of this change, the following language is added to your Certificate:

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

The above provisions supersede any language in the Contract or Certificate, under the definition of "Allowable Charge" or in any other section of the Contract/Certificate, outlining the manner in which claims are processed for services received from Out-of-Network/Non-Participating Providers or for services received outside the state of Oklahoma.

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

The provisions of this amendment are effective as follows:

1. For Employer Group Health Plans, this amendment is effective on the first of the following dates occurring on or after January 1, 2011:
   a. the Group Contract Date;
   b. the Group's first Contract Date Anniversary (renewal date); or
   c. the first Plan Year of the Group Health Plan.
2. For Health Check coverage, this amendment is effective on the Policy Year beginning January 1, 2011, or the effective date of the Certificate to which it is issued for attachment, whichever is later.
3. For Individual Conversion Contracts, this amendment is effective on the Policy Year beginning January 1, 2011, or the effective date of the Contract to which it is issued for attachment, whichever is later.

President of Blue Cross and Blue Shield of Oklahoma

BlueCross BlueShield of Oklahoma

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ENDORSEMENT RESPECTING ADDRESSES, DEFINITIONS, COVERED SERVICES, EXCLUSIONS, DUES, GENERAL PROVISIONS AND COMPLAINT/APPEAL PROCEDURE

IT IS AGREED that the Contract to which this Endorsement is issued for attachment is amended as set forth below:

A. **AMENDMENT RESPECTING ADDRESSES**

The following addresses are added for your use when corresponding with Blue Cross and Blue Shield of Oklahoma:

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

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

For Other Inquiries/Correspondence
Blue Cross and Blue Shield of Oklahoma
P.O. Box 3239
Naperville, IL 60566-7239

B. **AMENDMENT RESPECTING MEDICAL NECESSITY**

SECTION II – DEFINITIONS is amended so that the definition of "Medically Necessary (or Medical Necessity)" is hereby deleted and replaced by the following definition:

Medically Necessary (or Medical Necessity) – health care services that a Hospital, Physician, or other Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

a. in accordance with generally accepted standards of medical practice;

b. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and

c. not primarily for the convenience of the patient, Physician, or other health care Provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

C. **AMENDMENT RESPECTING ORAL CHEMOTHERAPY**

SECTION V – COVERED COMPREHENSIVE HEALTH CARE SERVICES, "OUTPATIENT THERAPY SERVICES", is amended by the addition of the following special provisions:

Outpatient Therapy Services do not include oral Chemotherapy or self-injectable Chemotherapy. These Prescription Drugs may be covered under your **Outpatient Prescription Drug Benefits**, if applicable, under this Contract.

D. **AMENDMENT RESPECTING OUTPATIENT THERAPY SERVICES**

The Benefits specified in the Contract for **Outpatient Physical Therapy** and **Outpatient Occupational Therapy** shall include Covered Services provided during a visit to the Subscriber's home, as well as visits to the Provider's office or other Outpatient visits.

E. **AMENDMENT RESPECTING PSYCHIATRIC CARE SERVICES**

1. **SECTION V – COVERED COMPREHENSIVE HEALTH CARE SERVICES,** is amended by the addition of the following special provisions under "**PSYCHIATRIC CARE SERVICES**"**:**

   a. "Inpatient Facility Services" are restated to include the following:

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

   b. "Outpatient Facility and Medical Services" are restated to include the following:

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

2. **SECTION II – DEFINITIONS** is amended by the addition of the following paragraphs:

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

   RESIDENTAL TREATMENT CENTER – a state licensed and/or state certified facility that provides a 24-hour level of residential care to patients with long-term or severe Mental Illnesses and/or substance abuse disorders. This care is medically monitored, with 24-hour Physician availability and 24-hour onsite nursing services.

F. **AMENDMENT RESPECTING PROSTHETIC APPLIANCES AND ORTHOTIC DEVICES**

The Benefits specified in the Contract for prosthetic appliances and orthotic devices are amended to include replacement appliances or devices when Medically Necessary.

G. **AMENDMENT RESPECTING OUTPATIENT PRESCRIPTION DRUGS AND RELATED SERVICES**

The Benefits specified in the Contract for **Outpatient Prescription Drugs and Related Services**, if applicable, are amended to include the following special provisions:

1. **Brand Name Drug Exclusion**

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

2. **Pharmacy Discount Programs**

   In an effort to help offset the rising cost of Prescription Drugs, drug manufacturers may offer coupons or other drug discounts or rebates to Subscribers, which may impact the Benefits provided under this program. The total Benefits payable will not exceed the balance of the Allowable Charges remaining after all drug coupons, rebates or other drug discounts have been applied. The Subscriber agrees to reimburse the Plan any excess amounts for Benefits that we have paid and for which the Subscriber is not eligible due to the application of drug coupons, rebates or other drug discounts.

H. **AMENDMENT RESPECTING EXCLUSIONS**

SECTION VI – EXCLUSIONS is amended as set forth below:

1. The following exclusions are hereby removed:
   a. For drug and alcohol treatment that is not rendered in a Hospital or by a psychiatrist, psychologist, licensed clinical social worker or person with a master's degree in social work.
   b. For services rendered by licensed professional counselors, marital and family therapists or counselors, or licensed drug and alcohol counselors.
2. The following exclusions are hereby added:
   a. For Inpatient drug and alcohol treatment that is not rendered in a Hospital, Psychiatric Hospital, Residential Treatment Center or other Plan-approved Provider.
   b. For massage therapy, including but not limited to effleurage, petrissage and/or tapotement.

I. **AMENDMENT RESPECTING DUES (PREMIUMS)**

SECTION VII – DUES is amended so that Paragraph A is deleted and restated as follows:

A. **AMOUNT OF DUES**

The amount of dues (premiums) shall be the amount determined by the Plan for the Benefits of this Contract, and as set forth in writing to each Member.

J. **AMENDMENT RESPECTING PLAN'S RIGHT OF RECOUPMENT**

SECTION VIII – GENERAL PROVISIONS is amended by the addition of the following provision under "**PLAN'S RIGHT OF RECOUPMENT**":

The Plan expressly disclaims all make whole and common fund rules and doctrines and any other rule or doctrine that would impair or interfere with the Plan's rights herein.

K. **SECTION X – COMPLAINT/APPEAL PROCEDURE** is amended by a change in the address for filing Level I and/or Level II appeals. Written requests for an appeal should be addressed to:

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

Except as otherwise specified in this Endorsement, or as required by federal or state regulation, the provisions of this endorsement are effective February 1, 2010, or the effective date of the Contract to which it is issued for attachment, whichever is later.

Except as amended, the Contract remains unchanged.

President of Blue Cross and Blue Shield of Oklahoma

BlueCross BlueShield of Oklahoma

1215 South Boulder • P. O. Box 3283 • Tulsa, OK 74102-3283

ENDORSEMENT TO PERSONAL BLUE INDIVIDUAL CONVERSION CONTRACT

IT IS AGREED that the Contract to which this Endorsement is issued for attachment is amended as set forth below:

I. **THE FOLLOWING AMENDMENTS ARE EFFECTIVE OCTOBER 13, 2008:**

A. **SECTION I – IMPORTANT INFORMATION** is amended as follows:

1. Paragraph E, **YOUR PRESCRIPTION DRUG PROGRAM**, is deleted in its entirety and replaced by the following paragraph:

E. **YOUR PRESCRIPTION DRUG PROGRAM**

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

HOW YOUR PRESCRIPTION DRUG PROGRAM WORKS

- ✓ Show your BlueChoice PPO Identification Card to your Pharmacy.
- ✓ If you choose a Participating Pharmacy, you will receive a discounted price for your prescriptions and your claims are filed automatically!
- ✓ Blue Cross and Blue Shield of Oklahoma will process your claims, subtract any Deductible and/or Coinsurance amounts which apply to your covered prescriptions, and forward the balance directly to you.
- ✓ Claims for Prescription Drugs purchased from a Participating Pharmacy are processed at the highest level of Benefits.

REMEMBER -- Using Participating Pharmacies can save you time and money. If you have any questions about your Prescription Drug coverage, please call a Customer Service Representative at 1-866-520-2507.

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

2. Paragraph F, **SELECTING A PROVIDER**, is deleted in its entirety and replaced by the following paragraph:

F. **SELECTING A PROVIDER**

A listing of Oklahoma BlueChoice PPO Providers is available on-line through the Blue Cross and Blue Shield of Oklahoma Web site at www.bcbsok.com.

You may also call a Customer Service Representative for assistance in locating a network Provider. Simply call our toll-free number: 1-866-520-2507.

Remember that you receive the highest level of Benefits under this Contract when you use BlueChoice PPO Providers.

3. Paragraph M, QUESTIONS, is deleted in its entirety and replaced by the following paragraph:

M. **QUESTIONS**

For help regarding your health care Benefit questions, please call a Customer Service Representative at 1-866-520-2507. Or, you can write:

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

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

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

B. **SECTION II – DEFINITIONS,** Paragraph 51, **PREEXISTING CONDITION**, is amended by the addition of the following provision:

"A Preexisting Condition includes pregnancy and/or Maternity Services."

C. **SECTION III – ELIGIBILITY** is amended so that Paragraph C is deleted in its entirety and replaced by the following provisions:

C. **EFFECTIVE DATE**

1. In order to be covered, you must submit an application for yourself and each of your Eligible Dependents in accordance with the Plan's underwriting and enrollment regulations. If the application is accepted, the Effective Date will be determined by the Plan.

2. If you are enrolled under Member Only Coverage, you may add coverage for a newborn child by submitting an application to the Plan within 31 days of the child's birth; and you must make the required contribution for such coverage from the date of birth. The Effective Date for the newborn child will be his/her birth date.

3. If you are enrolled under Member and Spouse Only Coverage, 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 of the child's birth; and you must make the required contribution for such coverage from the date of birth.

4. If you are enrolled under Member and Children Coverage or Member, Spouse and Children Coverage, no application will be required to add coverage for a newborn child. However, you

must notify the Plan of the child's birth. The Effective Date for the newborn will be the child's birth date.

5. Coverage may be added for an adopted child, including a child placed for adoption in the Member's custody. If application to add the child is received by the Plan within 31 days of the date the child is placed in the Member's custody, the Effective Date will be the date the Member assumed the physical custody of the adopted child and the financial responsibility for the support and care of the adopted child. A copy of the court order or adoption papers must be submitted to the Plan with the application.

   Subject to the Exclusions, conditions and limitations of this Contract, coverage for an adopted child will include the actual and documented medical costs associated with the birth of an adopted child who is 18 months of age or younger. You must provide copies for 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.

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

7. In the event of a divorce, your spouse may wish to continue Blue Cross and Blue Shield of Oklahoma coverage. He/she may apply for separate Individual Conversion coverage if application is received by the Plan no later than 60 days after the divorce is granted. Your Dependent children may continue to be eligible under your coverage or your spouse may obtain their own Dependent coverage.

8. Your spouse and Dependent children become ineligible for coverage under your Contract upon your death. However, your spouse and Dependent children may be eligible to change to a new Individual Conversion membership. To ensure continuous protection, the Plan must receive their application within 60 days following your death.

D. **SECTION V – COVERED COMPREHENSIVE HEALTH CARE SERVICES**, Paragraph E, **MATERNITY SERVICES**, is amended so that all references to a waiting period for Maternity Services are hereby deleted. Maternity Services shall be subject to the Preexisting Condition Limitations of this Contract.

E. **SECTION VI – EXCLUSIONS** is amended so that Paragraph A, **PREEXISTING CONDITION LIMITATION**, is hereby deleted and replaced with the following:

   A. **PREEXISTING CONDITION LIMITATION**

      1. If you transfer to this Contract within 60 days following termination of any coverage issued under any Blue Cross and/or Blue Shield Plan's names and service marks, or under the Blue Cross and Blue Shield Federal Employees Program, you will not be subject to a Preexisting Condition Limitation.

      2. If you add a Dependent to your coverage after your Effective Date, in accordance with the provisions of this Contract, coverage for that Dependent will be subject to a Preexisting Condition Limitation. This means that Benefits will not be provided for a Preexisting Condition, or for charges relating to a Preexisting Condition, until the Dependent's coverage has been in effect for 12 consecutive months.

F. **SECTION VIII – GENERAL PROVISIONS** is amended as follows:

   1. Paragraph F, **TERMINATION OF A SUBSCRIBER'S COVERAGE UNDER THIS CONTRACT,** is amended so that Subparagraph 1 is deleted and replaced by the following provisions:

1. When a Subscriber ceases to be an Eligible Person or Eligible Dependent, coverage for such Subscriber will terminate at the end of the coverage period during which eligibility ceases, except that, when a Subscriber ceases to be an Eligible Dependent by reason of death, coverage for that Subscriber will terminate on the date of death.

2. Paragraph H, **TRANSFER PRIVILEGES**, is amended so that Subparagraphs 1 and 2 are deleted and replaced by the following provisions:

   1. If a Subscriber ceases to be an Eligible Dependent under this Contract, he/she may apply for continuous coverage under an Individual Conversion Contract in his/her own name, subject to the applicable underwriting and enrollment regulations. Written application for a transfer in membership must be received by Blue Cross and Blue Shield of Oklahoma no later than:

      a. 60 days after the date of the Member's death; or

      b. 60 days after the date the Member is granted a divorce; or

      c. 31 days after the date a Dependent's coverage terminates for any reason other than the death or divorce of the Member.

      If the application is approved, the new Contract will be effective on the date of termination of the Subscriber's coverage under this Contract. Direct payment for the coverage must be made from the date the person ceases to be covered under this Contract.

   2. When you reach age 65, you may transfer coverage to the Plan's Medicare supplement program, Plan 65. If you apply within 31 days of termination from this Contract, your coverage will be continuous. Your spouse and your Dependent children, if any, may continue coverage under an Individual Conversion Contract in their name. When your spouse reaches age 65, he/she may also apply for Plan 65 coverage.

      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 65th birthday.

3. Paragraph K, **LIMITATION OF ACTIONS**, is hereby deleted and replaced by the following provisions:

   K. **LIMITATION OF ACTIONS**

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

4. Paragraph Q, **NOTICE**, is hereby deleted and replaced by the following provisions:

   Q. **NOTICE**

   Any notice required under this Contract must be in writing. Notice given to the Plan must be sent to:

   Blue Cross and Blue Shield of Oklahoma
   P.O. Box 3238
   Naperville, IL 60566-7238

   Notice given to you will be sent to your address as it appears on the Plan's records. You or the Plan may, by written notice, indicate a new address for giving notice.

G. **SECTION X – COMPLAINT/APPEAL PROCEDURE** is amended by a change in the address for filing Level I and/or Level II appeals. Written requests for an appeal should be addressed to:

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

H. **SECTION XI – CLAIMS FILING PROCEDURES**, Paragraph G, **DIRECT CLAIMS LINE**, is hereby deleted and replaced by the following:

G. **DIRECT CLAIMS LINE**

Blue Cross and Blue Shield of Oklahoma has a direct line for claims and membership inquiries. You may call 1-866-520-2507, between 8:00 a.m. and 6:00 p.m., Monday through Friday, whenever you have a question concerning a claim or your membership.

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II. **THE FOLLOWING AMENDMENT IS EFFECTIVE JANUARY 1, 2009:**

SECTION III – ELIGIBILITY, Subparagraph B, 2, is deleted in its entirety and replaced by the following Dependent eligibility provisions:

2. An Eligible Dependent child is defined as your unmarried child, including a newborn child, adopted child, stepchild, or other child for whom you or your spouse is legally responsible, including a child on whose behalf a qualified medical child support order (QMSCO) has been issued.

   a. Unmarried Dependent children are eligible for coverage until they reach age 19.

   b. Unmarried Dependent children who are medically certified as Totally Disabled and dependent upon you or your spouse are eligible for coverage regardless of age.

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

   The Plan also reserves the right to review a Physician's certificate of disability and/or request medical records 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 Dependent is Totally Disabled.

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These amendments are effective on the dates indicated above, or the effective date of the Contract to which this Endorsement is issued for attachment, whichever is later.

Except as amended, the Contract remains unchanged.

President of Blue Cross and Blue Shield of Oklahoma

BlueCross BlueShield of Oklahoma

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ENDORSEMENT RESPECTING HUMAN ORGAN, TISSUE AND BONE MARROW TRANSPLANT SERVICES

IT IS AGREED that the Contract to which this Endorsement is issued for attachment is amended as set forth below:

SECTION CH – COMPREHENSIVE HEALTH CARE SERVICES is amended so that the **"Human Organ, Tissue and Bone Marrow Transplant Services"** provisions are deleted in their entirety and replaced by the following provisions:

HUMAN ORGAN, TISSUE AND BONE MARROW TRANSPLANT SERVICES

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

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

A. **DEFINITIONS**

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

1. **Bone Marrow Transplant**

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

   a. 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);

   b. processing and/or storage of the stem cells or progenitor cells after harvesting;

   c. the administration of High-Dose Chemotherapy and/or High-Dose Radiation Therapy, when this step is prescribed by the treating Physician;

   d. the infusion of the harvested stem cells or progenitor cells; and

   e. 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.

2. **Experimental/Investigational**

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

   a. The drug, device, biological product, or medical treatment or procedure cannot be lawfully marketed without approval of the appropriate governmental or regulatory agency and approval for marketing has not been given at the time the drug, device, biological product, or medical treatment or procedure is furnished; or

   b. The drug, device, biological product, or medical treatment or procedure is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

   c. The prevailing opinion among peer reviewed medical and scientific literature regarding the drug, device, biological product, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

3. **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.

4. **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.

5. **Precertification**

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

6. **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.

B. **TRANSPLANT SERVICES**

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

1. Musculoskeletal transplants;
2. Parathyroid transplants;
3. Cornea transplants;
4. Heart-valve transplants;
5. Kidney transplants;
6. Heart transplants;
7. Single lung, double lung and heart/lung transplants;
8. Liver transplants;
9. Intestinal transplants;
10. Small bowel/liver or multivisceral (abdominal) transplants;
11. Pancreas transplants;
12. Islet cell transplants; and
13. Bone Marrow Transplants.

C. **EXCLUSIONS AND LIMITATIONS APPLICABLE TO ORGAN/TISSUE/BONE MARROW TRANSPLANT**

1. 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.
2. In addition to the Exclusions set forth elsewhere in this Contract, no Benefits will be provided for the following organ or tissue transplants or Bone Marrow Transplants or related services:
    a. Adrenal to brain transplants.
    b. Allogeneic islet cell transplants.
    c. 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.
    d. Small bowel transplants using a living donor.
    e. 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.
    f. Any artificial device for transplantation/implantation, except in limited instances as reflected in the Plan's written medical policies.
    g. Any organ or tissue transplant or Bone Marrow Transplant procedure which the Plan considers to be Experimental or Investigational in nature.

h. 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.

i. 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 Endorsement.

3. 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.

D. **DONOR BENEFITS**

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

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

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

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

4. 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.

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

E. **RESEARCH — URGENT BONE MARROW TRANSPLANT BENEFITS WITHIN NATIONAL INSTITUTES OF HEALTH CLINICAL TRIALS ONLY**

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

1. 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;

2. 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**;

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

4. The Bone Marrow Transplant is not excluded by another provision of this Contract.

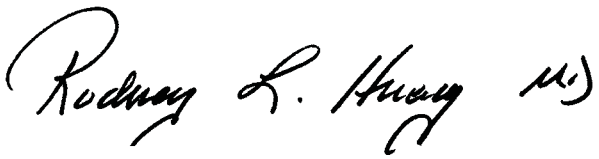
F. **LIFETIME MAXIMUM**

The Benefits provided under this Endorsement for human organ transplant, tissue transplant, and Bone Marrow Transplant services shall be subject to the same Lifetime Maximum provisions applicable to all other Benefits, as set forth in the Contract.

This Endorsement shall supersede any previous Endorsement for human organ transplant, tissue transplant and Bone Marrow Transplant services issued to the Group or Member, and/or any provisions for human organ transplant, tissue transplant and Bone Marrow Transplant services currently reflected in the Contract.

Except as amended, the Contract remains unchanged.

This Endorsement is effective on January 1, 2008, or the effective date of the Contract to which it is issued for attachment, whichever is later.



President of Blue Cross and Blue Shield of Oklahoma

BlueCross BlueShield
of Oklahoma
1215 South Boulder • P. O. Box 3283 • Tulsa, OK 74102-3283

ENDORSEMENT RESPECTING COVERED SERVICES, BENEFIT DETERMINATIONS AND EXCLUSIONS

IT IS AGREED that the Contract to which this Endorsement is issued for attachment is amended as set forth below:

A. **AMENDMENT RESPECTING CHILD HEALTH SUPERVISION SERVICES**

SECTION V – COVERED COMPREHENSIVE HEALTH CARE SERVICES, Subparagraph B, 3, h, is amended so that the Benefits described for "**Child Health Supervision Services**" are hereby deleted and restated as follows:

h. **Child Health Supervision Services.**

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

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

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

B. **AMENDMENT RESPECTING BENEFITS FOR ORGAN PROCUREMENT SERVICES**

SECTION V – COVERED COMPREHENSIVE HEALTH CARE SERVICES is amended so that the Benefits for "**Human Organ, Tissue and Bone Marrow Transplant Services**" shall no longer include a $15,000 Benefit maximum for Organ Procurement Services. Benefits for Organ Procurement Services will be determined by the Plan in accordance with its negotiated fees for facility and professional services.

C. **AMENDMENT RESPECTING BENEFIT DETERMINATIONS**

SECTION VIII – GENERAL PROVISIONS, Paragraph M, **DETERMINATION OF BENEFITS AND UTILIZATION REVIEW**, is amended by the addition of the following provision:

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

D. **AMENDMENT RESPECTING EXCLUSIONS**

SECTION VIII – EXCLUSIONS is amended by the addition of the following exclusions:

1. 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.
2. For ductal lavage of the mammary ducts.
3. 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.
4. For orthoptic training.
5. For thermal capsulorrhaphy as a treatment of joint instability, including but not limited to instability of shoulders, knees and elbows.
6. For transcutaneous electrical nerve stimulator (TENS).
7. For drug and alcohol treatment that is not rendered in a Hospital or by a psychiatrist, psychologist, licensed clinical social worker or person with a master's degree in social work.
8. For services rendered by licensed professional counselors, marital and family therapists or counselors, or licensed drug and alcohol counselors.
9. For services rendered by midwives.

This endorsement is effective October 15, 2006, or the effective date of the Contract to which it is issued for attachment, whichever is later.

Except as amended, the Contract remains unchanged.

President of Blue Cross and Blue Shield of Oklahoma

BlueCross BlueShield of Oklahoma

1215 South Boulder • P. O. Box 3283 • Tulsa, OK 74102-3283

ENDORSEMENT RESPECTING REINSTATEMENT AND ANNUAL MEETING

IT IS AGREED that the Contract to which this Endorsement is issued for attachment is amended as set forth below:

A. **AMENDMENT RESPECTING REINSTATEMENT OF COVERAGE FOLLOWING MILITARY ACTIVATION**

SECTION VIII – GENERAL PROVISIONS, Paragraph F**, TERMINATION OF A SUBSCRIBER'S COVERAGE UNDER THIS CONTRACT**, is amended by the addition of the following special provisions:

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

Reinstatement shall be granted, without medical underwriting, into the same coverage the Subscriber held prior to termination, in the same rating tier the Subscriber held prior to activation, and subject to the payment of the current premium charged to other persons of the same age and gender that are covered under the same coverage option.

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

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

B. **AMENDMENT RESPECTING ANNUAL MEMBERS MEETING**

SECTION VIII – GENERAL PROVISIONS, Paragraph U, **MEMBERS ANNUAL MEETING**, is deleted in its entirety and replaced by the following.

U. **NOTICE OF ANNUAL MEETING**

You are hereby notified that you are a Member of Blue Cross and Blue Shield of Oklahoma, a division of Health Care Service Corporation, a Mutual Legal Reserve Company ("HCSC"), and

you are entitled to vote in person, or by proxy, at all meetings of HCSC. The annual meeting is held at our principal office at 300 East Randolph, Chicago, Illinois each year on the last Tuesday in October at 12:30 p.m.

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

This endorsement is effective October 15, 2006, or the effective date of the Contract to which it is issued for attachment, whichever is later.

Except as amended, the Contract remains unchanged.

President of Blue Cross and Blue Shield of Oklahoma

BlueCross BlueShield
of Oklahoma

1215 South Boulder • P. O. Box 3283 • Tulsa, OK 74102-3283

ENDORSEMENT RESPECTING PRESCRIPTION DRUG PRECERTIFICATION PROCESS

IT IS AGREED that the Contract to which this Endorsement is issued for attachment is amended so that the Benefits for Outpatient Prescription Drugs shall be subject to the following Precertification requirements. This Endorsement shall supersede any previous endorsement respecting Prescription Drug Precertification issued to the Group or Member, and/or any Prescription Drug Precertification provisions currently reflected in the Contract.

A. The Plan has designated certain drugs for which the Subscriber must receive prior authorization (Precertification) in order for Benefits to be provided under the Contract. Precertification for certain medications may include the Plan's Step Therapy program. Step Therapy may require a Subscriber to try one or more "prerequisite" medications before certain high-cost medications are approved for coverage under the Prescription Drug program.

B. Precertification may be requested by the Subscriber or Physician before the drug is dispensed. When the Subscriber presents his/her prescription to a Participating Pharmacy, the pharmacist will submit an electronic claim to the Plan to determine the appropriate Benefits.

   1. If the Precertification request is approved, the pharmacist will dispense the Prescription Order and collect the appropriate Deductible, Copayment and/or Coinsurance amount from the Subscriber.

   2. If the Precertification request is denied, the pharmacist will receive an electronic message indicating that Benefits are not available for the drugs. The Subscriber will be responsible for the full cost of the prescription.

C. If prior approval of the drug has not been requested, Precertification may be coordinated through a Participating Pharmacy at the time the Prescription Order is presented, in accordance with the following guidelines:

   1. When the Participating Pharmacy submits a claim electronically, he/she will receive a message indicating that Precertification is required.

   2. At the Subscriber's request, the Pharmacy may dispense a three-day supply of the drug while the Plan completes the Precertification approval process. The pharmacist will collect the appropriate Deductible, Copayment and/or Coinsurance amount from the Subscriber at the time of purchase.

   3. Once the three-day supply has been used, the Subscriber may return to the Pharmacy to obtain the remainder of his/her Prescription Order. The Participating Pharmacy will resubmit the claim electronically to determine whether the Precertification request has been approved or denied.

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

b. If the Precertification is denied, the Subscriber may obtain the Prescription Order by paying the full cost for the drugs.

c. Whether the Plan approves Precertification for the drug, or whether the Plan determines that the prescribed drug does not meet its guidelines for Medical Necessity for the condition being treated, the Subscriber will be notified of that decision.

D. If the Subscriber purchases a Prescription Drug from an Out-of-Network Pharmacy, or fails to present his/her identification card to a Participating Pharmacy at the time of purchase, the Subscriber will be responsible for paying the full cost of the Prescription Order. The Subscriber may submit a claim form to the Plan in accordance with the "Notice and Properly Filed Claim" provisions set forth in the Contract.

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

This endorsement is effective October 15, 2006, or the effective date of the Contract to which it is issued for attachment, whichever is later.

Except as amended, the Contract remains unchanged.

President of Blue Cross and Blue Shield of Oklahoma

BlueCross BlueShield of Oklahoma

1215 South Boulder • P. O. Box 3283 • Tulsa, OK 74102-3283

ENDORSEMENT RESPECTING GYNECOLOGICAL/OBSTETRICAL EXAMINATION AND PAP SMEAR

IT IS AGREED that the Contract to which this Endorsement is issued for attachment is amended as set forth below:

A. **SECTION SB – SCHEDULE OF BENEFITS** is amended as follows:

a. The Deductible shall not apply to an annual routine gynecological/obstetrical examination and Pap smear.

b. The Benefit Percentage Amount paid by the Plan for an annual routine gynecological/obstetrical examination and Pap smear shall be 100% of the Allowable Charge.

B. **SECTION CH – COVERED COMPEHENSIVE HEALTH CARE SERVICES,** Paragraph B, 3, Outpatient Medical Services, is amended so that Subparagraph d, is deleted and replaced by the following provision:

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

Except as amended, the Contract remains unchanged.

BLUE CROSS AND BLUE SHIELD OF OKLAHOMA **ATTEST:**

Chief Executive Officer

Secretary

BlueCross BlueShield of Oklahoma

1215 South Boulder • P. O. Box 3283 • Tulsa, OK 74102-3283

ENDORSEMENT RESPECTING COMPLICATIONS OF PREGNANCY

The Contract to which this Endorsement is issued for attachment is amended by the addition of the following special provisions.

A. The term "complications of pregnancy," wherever used in the Contract or in any Endorsement issued thereto, shall be amended to include the following diagnoses:

"Diagnoses represented by ICD-9 Codes (International Classification of Diseases, 9th Edition) which appear under the section entitled 'Complications of Pregnancy, Childbirth, and the Puerperium,' under headings of Ectopic and Molar Pregnancy and Complications Mainly Related to Pregnancy (except induced abortion and early or threatened labor or late pregnancy, or 'Other current conditions in the mother classifiable elsewhere, but complicating pregnancy, childbirth or the puerperium'), and under subheadings of Postpartum hemorrhage; Retained placenta or membranes, without hemorrhage; Complications of the administration of anesthetic or other sedation in labor and delivery; Shock during or following labor and delivery; Maternal hypotension syndrome; Acute renal failure following labor and delivery; Venous complications in pregnancy and the puerperium; Pyrexia of unknown origin during the puerperium; or Obstetrical pulmonary embolism."

B. Maternity Services for Dependent children are not covered under the Contract, except for complications of pregnancy.

Except as amended, the Contract remains unchanged.

BLUE CROSS AND BLUE SHIELD OF OKLAHOMA **ATTEST:**

Chief Executive Officer

Secretary

BlueCross BlueShield of Oklahoma

1215 South Boulder • P. O. Box 3283 • Tulsa, OK 74102-3283

ENDORSEMENT RESPECTING EXCLUSIONS

IT IS AGREED that the Contract to which this Endorsement is issued for attachment is amended as set forth below:

A. **SECTION CH – COMPREHENSIVE HEALTH CARE SERVICES** is amended as follows:

1. The "Human Organ, Tissue and Bone Marrow Transplant Services" section is amended so that the exclusion for "tandem transplants" is deleted and replaced by the following exclusion:

   Tandem transplants for autologous or allogeneic Bone Marrow or stem cell or progenitor cell treatment or rescue, with or without High-Dose Chemotherapy and/or High-Dose Radiation Therapy, except for a tandem transplant for autologous Bone Marrow or stem cell or progenitor cell treatment or rescue with High-Dose Chemotherapy to treat newly diagnosed or responsive multiple myeloma, only.

2. The "Psychiatric Care Services" section is amended so that "Outpatient Convulsive Therapy Treatment " is no longer excluded.

3. The "Dental Services for Accidental Injury" section is amended by deletion of the language requiring that the accident must have occurred *on or after the Effective Date*.

B. **SECTION EX – EXCLUSIONS** is amended as follows:

1. Exclusions requiring that an accident must have occurred on or after the Effective Date are hereby removed. All Benefits shall remain subject to the Preexisting Condition Exclusions and Limitations specified in the Contract.

2. The exclusions for "attempted suicide" or "intentionally self-inflicted injury" shall no longer apply.

3. The exclusion for services related to "war or any act of war" is hereby deleted and replaced by the following exclusion:

   For any illness or injury suffered after the Subscriber's Effective Date as a result of war or act of war (whether declared or undeclared) while serving in the military or an auxiliary unit attached to the military or working in an area of war whether voluntarily or as required by an employer.

4. The exclusion for "telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form" is amended by the addition of "**email or other electronic consultations**" to the list of excluded services.

5. The exclusion for "conditions related to autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems, mental retardation, or for Inpatient confinement for environmental change" is amended by the addition of the following provision:

   This exclusion *shall not* apply to the following Medically Necessary services:

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

   b. Prescription Drug therapy (provided the Contract includes Benefits for Outpatient Prescription Drugs) for treatment of ADD/ADHD in Subscribers age 19 and under.

6. The exclusions for "routine or periodic physical examinations" and "screening examinations, including x-ray examinations made without film" are hereby deleted and replaced by the following exclusion:

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

7. The following exclusions are hereby added:

   a. **For family or marital counseling;**

   b. **For hippotherapy, equine assisted learning, or other therapeutic riding programs.**

Except as amended, the Contract remains unchanged.

BLUE CROSS AND BLUE SHIELD OF OKLAHOMA **ATTEST:**

Chief Executive Officer

Secretary

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1215 South Boulder • P. O. Box 3283 • Tulsa, OK 74102-3283

ENDORSEMENT RESPECTING OUTPATIENT PRESCRIPTION DRUGS AND EXCLUSIONS

IT IS AGREED that the Contract/Agreement to which this Endorsement is issued for attachment is amended as set forth below:

A. The term "Prescription Drug", wherever used in the Contract/Agreement shall be defined as follows:

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

B. Subject to the exclusions, conditions and limitations of the Contract/Agreement, coverage for Outpatient Prescription Drugs, whether contained in the Contract/Agreement or in a separate Endorsement, are amended to include the following Covered Services:

OUTPATIENT PRESCRIPTION DRUGS AND RELATED SERVICES

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

1. Prescription Drugs dispensed for a Subscriber's Outpatient use, when recommended by and while under the care of a Physician or other Provider;

2. Injectable insulin and insulin products, but only when dispensed in accordance with a written prescription by a licensed Physician;

3. Oral contraceptives, when prescribed by a licensed Physician; and

4. Self-injectable Prescription Drugs, when dispensed by a Pharmacy. Self-injectable drugs purchased from a Physician and administered in his/her office are not covered.

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

C. The "**EXCLUSIONS"** section is amended by the addition of the following exclusions:

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

2. Prescription Drugs prescribed and used for cosmetic purposes.

Except as amended, the Contract/Agreement remains unchanged.

This Endorsement is effective on January 1, 2004, or the effective date of the Contract/Agreement to which it is issued for attachment, whichever is later.

BLUE CROSS AND BLUE SHIELD OF OKLAHOMA **ATTEST:**

Chief Executive Officer

Secretary

BlueCross BlueShield of Oklahoma

1215 South Boulder ● P. O. Box 3283 ● Tulsa, OK 74102-3283

ENDORSEMENT RESPECTING THE BLUECARD PROGRAM

IT IS AGREED that the Contract/Membership Agreement to which this Endorsement is issued for attachment is amended by the addition of the following special provisions:

BLUECARD

Like all Blue Cross and Blue Shield Licensees, Blue Cross and Blue Shield of Oklahoma participates in a program called "BlueCard." Whenever Subscribers access health care services outside the geographic area Blue Cross and Blue Shield of Oklahoma serves, the claim for those services may be processed through BlueCard and presented to Blue Cross and Blue Shield of Oklahoma for payment in conformity with network access rules of the BlueCard Policies then in effect ("Policies"). Under BlueCard, when Subscribers receive covered health care services within the geographic area served by an on-site Blue Cross and/or Blue Shield Licensee ("Host Blue"), Blue Cross and Blue Shield of Oklahoma will remain responsible to the Subscriber for fulfilling its contract obligations. However, the Host Blue will only be responsible, in accordance with applicable BlueCard Policies, if any, for providing such services as contracting with its participating Providers and handling all interaction with its participating Providers. The financial terms of BlueCard are described generally below.

LIABILITY CALCULATION METHOD PER CLAIM

The calculation of Subscriber liability on claims for covered health care services Incurred outside the geographic area Blue Cross and Blue Shield of Oklahoma serves and processed through BlueCard will be based on the lower of the Provider's billed charges or the negotiated price Blue Cross and Blue Shield of Oklahoma pays the Host Blue.

The methods employed by a Host Blue to determine a negotiated price will vary among Host Blues based on the terms of each Host Blue's Provider contracts. The negotiated price paid to a Host Blue by Blue Cross and Blue Shield of Oklahoma on a claim for health care services processed through BlueCard may represent:

1. the actual price paid on the claim by the Host Blue to the health care Provider ("Actual Price"); or
2. an estimated price, determined by the Host Blue in accordance with BlueCard Policies, based on the Actual Price increased or reduced to reflect aggregate payments expected to result from settlements, withholds, any other contingent payment arrangements and non-claims transactions with all of the Host Blue's health care Providers or one or more particular Providers ("Estimated Price"); or
3. an average price, determined by the Host Blue in accordance with BlueCard Policies, based on a billed charges discount representing the Host Blue's average savings expected after settlements, withholds, any other contingent payment arrangements and non-claims transactions for all of its Providers or for a specified group of Providers ("Average Price"). An Average Price may result in greater variation to the Subscriber from the Actual Price than would an Estimated Price.

Host Blues using either the Estimated Price or an Average Price will, in accordance with BlueCard Policies, prospectively increase or reduce the Estimated Price or Average Price to correct for overestimation or underestimation of past prices. However, the amount paid by the Subscriber is a final price and will not be affected by such prospective adjustment.

Statutes in a small number of states may require a Host Blue either (1) to use a basis for calculating Subscriber liability for covered health care services that does not reflect the entire savings realized, or expected to be realized, on a particular claim, or (2) to add a surcharge. Should any state statutes mandate liability calculation methods that differ from the negotiated price methodology or require a surcharge, the Host Blue would then calculate Subscriber liability for any covered health care services in accordance with the applicable state statute in effect at the time the Subscriber received those services.

Blue Cross and Blue Shield of Oklahoma may postpone application of the Subscriber's Deductible, Coinsurance and/or Copayment amounts whenever it is necessary in order to obtain Provider discounts for Covered Services the Subscriber receives outside the state of Oklahoma.

* * * * * * * * * *

This Endorsement shall supersede any previous Endorsement Respecting the BlueCard Program issued to the Member, and/or the BlueCard provisions currently reflected in the Contract/Agreement.

Except as amended, the Contract/Agreement remains unchanged.

BLUE CROSS AND BLUE SHIELD OF OKLAHOMA **ATTEST:**

Chief Executive Officer

Secretary

BlueCross BlueShield of Oklahoma

1215 South Boulder ● P. O. Box 3283 ● Tulsa, OK 74102-3283

ENDORSEMENT RESPECTING DURABLE MEDICAL EQUIPMENT

The Contract/Agreement to which this Endorsement is issued for attachment is amended by the addition of the following special provisions:

A. The **DEFINITIONS** section is amended so that the current definition of "Durable Medical Equipment" is hereby deleted, and the following definition is inserted therefor:

DURABLE MEDICAL EQUIPMENT – equipment which meets the following criteria:

1. 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;
2. It can withstand repeated use and is primarily and customarily used to serve a medical purpose;
3. It is generally not useful to a person in the absence of an illness or injury and is appropriate for use in the home; and
4. It is prescribed by a Physician and meets the Plan's criteria of Medical Necessity for the given diagnosis.

B. The "**COVERED SERVICES"** section is amended so that the current provisions for "**DURABLE MEDICAL EQUIPMENT**" are deleted in their entirety and the following provisions are hereby added:

DURABLE MEDICAL EQUIPMENT

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

1. 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;
2. It can withstand repeated use and is primarily and customarily used to serve a medical purpose;
3. It is generally not useful to a person in the absence of an illness or injury and is appropriate for use in the home; and
4. It is prescribed by a Physician and meets the Plan'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 control or to enhance the environmental setting or surroundings of an individual are not included, such as air conditioners, air filters, portable Jacuzzi pumps, humidifiers, or modifications to the Subscriber's home or vehicle.

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

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

Except as amended, the Contract/Agreement remains unchanged.

BLUE CROSS AND BLUE SHIELD OF OKLAHOMA **ATTEST:**

Chief Executive Officer

Secretary

BlueCross BlueShield of Oklahoma

1215 South Boulder ● P. O. Box 3283 ● Tulsa, OK 74102-3283

ENDORSEMENT RESPECTING DEFINITIONS

The Contract/Agreement to which this Endorsement is issued for attachment is amended so that the definitions for Chemotherapy," "Experimental/Investigational" and "Total Disability/Totally Disabled" are hereby deleted and replaced by the following definitions:

A. **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."

B. **EXPERIMENTAL/INVESTIGATIONAL**

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

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

B. **TOTAL DISABILITY (OR TOTALLY DISABLED)**

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

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

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

Except as amended, the Contract/Agreement remains unchanged.

BLUE CROSS AND BLUE SHIELD OF OKLAHOMA

Chief Executive Officer

ATTEST:

Secretary

BlueCross BlueShield of Oklahoma

Value-added programs, tools and services are just another advantage of being a Blue Cross and Blue Shield of Oklahoma (BCBSOK) member.

Blue Access for Members℠*

Your gateway to health information

It's easy to register and find what you need at ***bcbsok.com/member****.*

When it comes to managing your health information, it's "easy does it" with our Blue Access for Members (BAM) member site. BAM gives you important health and benefits information that you can manage in one convenient place online.

Go to bcbsok.com, click "Log In" and register to access:

- your personal health history
- benefits highlights, claims, explanations of benefits and forms
- health and wellness resources
- special member discounts and programs

Blue Access Mobile℠

With Blue Access Mobile, you have access to real-time claims status, ID cards and coverage details. Now you can get that information while on the go because BAM is mobile!

** Blue Access for Members is not available on child only policies.*

Provider Finder

Easily search for physicians, specialists and hospitals

It's easy to find physicians, specialists and hospitals with the online Provider Finder. Follow these three steps:

1. Visit bcbsok.com
2. Click Provider Finder
3. Search by network, doctor, hospital or area to find the most up-to-date listing of health care providers

Download the free Provider Finder® App for Android or iPhone

In addition to finding a provider when you're on the go, this app can perform a GPS search and get directions to the provider's location.

70805.0413

Well onTarget℠

Motivation and guidance on the path to health and wellness

The Well onTarget program offers an expanded array of personalized tools and resources designed to plan, engage, motivate, sustain and measure, with the end goal of delivering the best wellness experience to members.

Well onTarget includes wellness programs such as:

- Onmyway™ health assessment
- Health and wellness content
- Liveon wellness member portal
- Fitness program and incentives
- Onmytime self-directed courses

Learn more at wellontarget.com.

BlueCare® Dental PPO

For individuals and families

Something to smile about…
Maximum dental coverage that doesn't take a big bite out of your wallet!

You'll get preventive dental coverage on day one – with no deductible required – for checkups, cleanings and other preventive services. You can choose any dentist you want, with no referrals needed.

By choosing the BlueCare Dental PPO plan from BCBSOK, you can be certain that the savings will add up. In fact, with BlueCare Dental PPO, you'll get one of the highest maximum annual benefit levels available – up to $1,500 per person per year.

For information on eligibility requirements and to sign up for dental coverage that fits your needs, please call us toll-free at 888-454-5590.

Blue365®

Member discount program

Blue365 is just one more advantage of being a BCBSOK member. With this program, you can save money on health care products and services that are most often not covered by your benefit plan. There are no claims to file and no referrals or pre-authorizations.

You can sign up for Blue365, our member discount program that offers deals from brands like Reebok, Jenny Craig® and Nutrisystem®. Log in to Blue Access for Members or visit ***www.Blue365Deals.com/BCBSOK/***.

Davis Vision℠ and TruVision
888-897-9350 or 877-882-2020

Save on eyeglasses as well as contact lenses, laser vision correction services, examinations and accessories. Find out more when you log in to BAM. For a list of Davis Vision providers near you, go to bcbsok.com, click Find a Doctor, then select Find a Vision Provider. The Davis Vision network has major national and regional retail locations as well as independent ophthalmologists and optometrists. You and your eligible dependents can receive discounts on laser vision correction services through the TLC/TruVision network.

Jenny Craig®
877-JENNY70 (877-536-6970)

Jenny Craig can help you reach your weight loss goals. You will get one-on-one support from a trained weight loss expert. Your consultant will give you a tailored program based on the basic components of successful weight management: food, body, mind. You can meet with your consultant in person at a local center. Or you can enjoy the ease of the Jenny Craig At Home program. To get a special savings coupon, log in to BAM.

Life Time® Fitness
Life Time Fitness offers a total health fitness experience no matter your fitness level, interests, schedule or budget. For new members, Life Time Fitness offers a $0 enrollment fee when you sign up online.* Log in to BAM and access the Life Time Fitness website to find a free, seven-day pass to try out the location nearest you.

Procter & Gamble (P&G) Dental Products
877-333-0121

Get savings on dental packages containing the latest in Oral B® power toothbrushes and Crest® products. The dental packages from P&G can help you improve the health of your teeth and gums. Packages may contain items such as an electronic toothbrush, mouth rinse, floss, and many more. To shop in the P&G estore, log in to BAM and click on Member Discounts under Quick Links.

** Proof of Blue Cross and Blue Shield of Oklahoma coverage is needed. The $0 enrollment fee offer is only for new members who enroll online at www.Blue365Deals.com/BCBSOK/. A $35 administrative fee applies to all memberships. Monthly dues and taxes may also apply. Members' prices, dues and fees may change at any time. Offer expires September 1, 2013. Other rules may apply. Always check with the Life Time Fitness club in your area for the most up-to-date offer. Offer not available in Minnesota.*

The relationship between these vendors and Blue Cross and Blue Shield of Oklahoma (BCBSOK) is that of independent contractors.

Blue365 is a discount program only for BCBSOK members. This is NOT insurance. Some of the services offered through this program may be covered under your health plan. Please check your benefit booklet or call the customer service number on the back of your ID card for specific benefit facts. Use of Blue365 does not change your monthly payment, nor do costs of the services or products count toward any maximums and/or plan deductibles. Discounts are only given through vendors who take part in this program. BCBSOK does not guarantee or make any claims or recommendations about the program's services or products. You may want to talk to your doctor before using these services and products. BCBSOK reserves the right to stop or change this program at any time without notice.

Mail service for prescriptions

It's all about convenience

As a BCBSOK member, you have a mail-service prescription drug program available for your maintenance medications. This benefit saves you time and money. Members pay a copayment, coinsurance or a combination, depending on their plan. Just ask your doctor for a written prescription for up to 90 days for each medication you want delivered to your home. You can find more information on BAM under the **My Coverage** tab.

If you have any questions about cost or benefit coverage, call the Blue Cross and Blue Shield Pharmacy Line at 800-423-1973, Monday through Friday, 7 a.m. to 11 p.m., and Saturday and Sunday 7:30 a.m. to 8 p.m. CT. Have your Blue Cross and Blue Shield ID card handy when you call.

Travel with confidence

You're covered!

With our BlueCard® PPO Program, Blue Cross and Blue Shield (BCBS) Plans across the country work together to ensure you receive reliable, affordable health care whenever you're away from home. When you use BlueCard PPO network providers (even while traveling outside your local Plan service area), you will receive the network benefits available through your health plan.

So, when you need medical services outside your local Plan service area, call the customer service telephone number on the back of your ID card. Or call the BlueCard Access telephone number at 800-810-BLUE (2583). The "suitcase" logo on your ID card tells providers that you are part of the BlueCard PPO Program.

Learn more about taking care of your health

Facebook

facebook.com/bluecrossblueshieldofoklahoma

Twitter

twitter.com/bcbsok

YouTube

youtube.com/bcbsok

Blue Cross Blue Shield of Oklahoma

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

This notice describes how Blue Cross and Blue Shield of Oklahoma can use or disclose your medical information and how you can get access to this information. Our contact information can be found at the end of the notice. **Please review this notice carefully.**

YOUR RIGHTS. When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records	***** You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this by using the contact information at the end of this notice. ***** We will provide a copy or a summary of your health and claims records usually within 30 days of the request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	***** You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this by using the contact information at the end of this notice. ***** We may say "no" to your request. We'll tell you why in writing within 60 days.
Request confidential communications	***** You can ask us to contact you in a specific way or to send mail to a different address Ask us how to do this by using the contact information at the end of this notice. ***** We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	***** You can ask us **not** to share or use certain health information for treatment, payment or our operations. Ask how to do this by using the contact information at the end of this notice. ***** We are not required to agree to your request, and we may say "no" if it would affect your care.
Get a list of those with whom we've shared information	***** You can ask for a list (accounting) for six years prior to your request date of when we shared your information, who we shared it with and why. Ask us how to do this by using the contact information at the end of this notice. ***** We will include all the disclosures except for those about treatment, payment, and our operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but we may charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this notice	***** You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. To request a copy of this notice, use the contact information at the end of this notice and we will send you one promptly.
Choose someone to act for you	***** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. Ask us how to do this by using the contact information at the end of this notice. ***** We confirm the person has the authority and can act for you before we share your information.

BlueCross BlueShield of Oklahoma

YOUR RIGHTS (continued)

File a complaint if you feel your rights are violated	***** You can complain if you feel we have violated your privacy rights by using the contact information at the end of this notice. ***** You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by calling 1-877-696-6775; or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/ or by sending a letter to them at: 200 Independence Ave., SW, Washington, D.C. 20201. ***** We will not retaliate against you for filing a complaint.

YOUR CHOICES. For certain health information, you can tell us your choices about what we share.

If you have a clear preference on how you want us to share your information in the situations described below, tell us and we will follow your instructions. Use the contact information at the end of this notice.

In these cases, you have both the right and choice to tell us to:	***** Share information with your family, close friends, or others involved in payment for your care ***** Share information in a disaster or relief situation ***** Contact you for fundraising efforts

If you cannot share your preference, for example, if you are unconscious, we can share your information if we think it is in your best interest. We may share information when needed to lessen a serious or imminent threat to health or safety.

We *never share your* information in these situations unless you give us written permission	***** Marketing purposes ***** Sale of your information

OUR USES AND DISCLOSURES. How do we use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive	***** We can use your health information and share it with professionals who are are treating you.	***** *Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*
Run our organization	***** We can use and disclose your information to run our organization and contact you when necessary.	***** *Example: We use health information to develop better services for you.*

We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. *This does not apply to long-term care plans.*

Pay for your health services	***** We can use and disclose your health information since we pay for your health services.	***** *Example: We share information about you with your dental plan to coordinate payment for your dental work.*

Administer your plan	***** We may disclose your health information to your health plan sponsor for plan administration purposes.	*******Example: If your company contracts with us to provide a health plan, we may provide them certain statistics to explain the premiums we charge.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways, usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information go to: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	***** We can share your health information for certain situations such as: ***** Preventing disease ***** Helping with product recalls ***** Reporting adverse reactions to medications ***** Reporting suspected abuse, neglect or domestic violence ***** Preventing or reducing a serious threat to anyone's health or safety
Do research	***** We can use or share your information for health research.
Comply with the law	***** We will share information about you when state or federal law requires it, including the Department of Health and Human Services if they want to determine that we are complying with federal privacy laws.
Respond to organ/tissue donation requests and work with certain professionals	***** We can share health information about you with an organ procurement organization. ***** We can share information with a medical examiner, coroner or funeral director.
Address workers' compensation, law enforcement, and other government requests	***** We can use or share health information about you: ***** For workers' compensation claims ***** For law enforcement purposes or with a law enforcement official ***** With health oversight agencies for activities authorized by law ***** For special government functions such as military, national security, and presidential protective services or with prisons regarding inmates.
Respond to lawsuits and legal actions	***** We can share health information about you in response to an administrative or court order, or in response to a subpoena.
Certain health information	***** State law may provide additional protection on some specific medical conditions or health information. For example, these laws may prohibit us from disclosing or using information related to HIV/AIDS, mental health, alcohol or substance abuse and genetic information without your authorization. In these situations, we will follow the requirements of the state law.

OUR RESPONSIBILITIES. When it comes to your information, we have certain responsibilities.

* We are required by law to maintain the privacy and security of your protected health information.
* We will let you know promptly if a breach occurs that compromises the privacy or security of your information.
* We must follow the duties and privacy practices described in this notice and give you a copy of it.
* We will not use or share your information other than as described here unless you tell us we can in writing.

You may change your mind at any time. Let us know in writing if you change your mind.

For more information: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes we make will apply to all information we have about you. The new notice will be available upon request or from our website. We will also mail a copy of the new notice to you if there are material changes to our privacy practices.

CONTACT INFORMATION

If you would like general information about your privacy rights or would like a copy of this notice, go to: http://www.bcbsok.com/important_info/index.html. If you have specific questions about your rights or about this notice, you may contact us in one of the following ways:

* Call us at the toll-free number on the back of your member identification card.
* Call us at 1-877-361-7594.
* Write us at:

Divisional Vice President, Privacy Office
Blue Cross and Blue Shield of Oklahoma
P.O. Box 804836
Chicago, IL 60680-4110

EFFECTIVE DATE OF THIS NOTICE

September 23, 2013