

Your Health Care Benefit Program



For Participants of
Oklahoma Conference of
The United Methodist Church

Effective January 1, 2011

Administered by:



BlueCross BlueShield of Oklahoma

Experience. Wellness. Everywhere.™

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Plan Summary

Oklahoma Conference of The United Methodist Church (called the *Plan Sponsor*) has established and maintains a self-insured Plan of Comprehensive Health Care Benefits (called the *Plan*) for its eligible Participants and other persons as designated in its personnel policy.

The Plan is operated under an Administrative Services Agreement between Oklahoma Conference of The United Methodist Church and Blue Cross and Blue Shield of Oklahoma, a division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association, (called **BCBSOK** or the *Claims Administrator*).

Under this Agreement, BCBSOK pays Benefits on behalf of the Plan Sponsor in accordance with the terms of the Plan and performs certain other services on behalf of the Plan Sponsor. The Plan Sponsor reserves the right to amend or cancel any or all provisions of the Plan at any time as it relates to any Covered Person.

The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

This benefit booklet is issued according to the terms of the Plan. It is not a summary plan description. It is only a summary of Benefits, and all statements in this benefit booklet are subject to the terms of the Plan documents on file in your Human Resources Department.

This benefit booklet replaces any and all summaries, certificates or benefit booklets previously issued for the Participants under the Plan. It describes the Plan in effect as of January 1, 2011, for all Covered Persons (called “you” or “your”).

Important Information

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

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

THE BLUECHOICE PPO PROVIDER NETWORK

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

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

HOW YOUR BLUECHOICE PPO COVERAGE WORKS

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

In contrast, when care is received from a Physician who is not a member of the BlueChoice PPO Provider Network, a *higher* Coinsurance and Out-of-Pocket Limit will apply to most Covered Services. However, if a Covered Person receives services from an Out-of-Network Provider in a BlueChoice PPO or BlueCard PPO Hospital for anesthesiology, radiology, laboratory or pathology services, Benefits will be provided as if such services were received under the same conditions from a PPO Provider.

COST SHARING FEATURES OF YOUR COVERAGE

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

SELECTING A PROVIDER

A listing of Oklahoma BlueChoice PPO Providers are available on-line through the Blue Cross and Blue Shield of Oklahoma Web site at www.bcbsok.com. **Although every effort is made to provide an accurate listing of network Providers, additions and deletions will occur.** Therefore, you should check with Blue Cross and Blue Shield of Oklahoma or the Provider to be sure of the Provider's BlueChoice PPO status.

If you do not have Internet access, you may obtain Provider information, including a listing of BlueChoice PPO Providers, by contacting a Customer Service Representative at 1-800-942-5837.

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

THE BLUECARD PPO PROGRAM

The BlueCard Program allows you to use a Blue Cross and Blue Shield PPO Physician or Hospital outside the state of Oklahoma and to receive the advantages of PPO benefits and savings.

- **Finding a PPO Physician or Hospital**

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

- **Available Care Coast to Coast**

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

- **Remember to Always Carry the BlueCard**

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

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

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

HOW THE BLUECARD PPO PROGRAM WORKS

- ✓ You're outside the state of Oklahoma and need health care.
- ✓ Call 1-800-810-BLUE (2583) for information on the nearest PPO Physicians and Hospitals, or visit the BlueCard Web site at <http://www.bluecares.com>.
- ✓ You are responsible for Preauthorization 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 Copayment, Deductible and/or Coinsurance payments, if any.
- ✓ All PPO Physicians and Hospitals are paid directly, relieving you of any hassle and worry.

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

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

PREAUTHORIZATION/PRE CERTIFICATION

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

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

If you utilize a network Provider for Covered Services, that Provider *may* request Preauthorization for the services. However, it is *your* responsibility to assure that the services are Preauthorized before you receive care.

- **Preauthorization Process for Inpatient Services**

For an Inpatient facility stay, you must request Preauthorization from the Claims Administrator *before* your scheduled admission. The Claims Administrator will consult with your Physician, Hospital, or other facility to determine if Inpatient level of care is required for your illness or injury. The Claims Administrator 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 Claims Administrator 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 Claims Administrator’s approval, or if you do not ask the Claims Administrator for Preauthorization, your Benefits under the Plan will be reduced as described below under “Failure to Preauthorize,” provided the Claims Administrator determines that Benefits are payable upon receipt of a claim.** This reduction applies in addition *to* any penalties associated with your use of an Out-of-Network Provider.

For Preauthorization requests related to Urgent Care or Emergency Care, the Covered Person should refer to the Preauthorization procedures outlined below in this *“Preauthorization/Precertification”* section.

- **Preauthorization Process for Psychiatric Care Services**

All **Inpatient and Outpatient** services related to treatment of Mental Illness (including severe Mental Illness), drug addiction, substance abuse, or alcoholism must be Preauthorized by the Plan. You or your Physician must call the Preauthorization number shown on the Covered Person’s Identification Card **before** receiving treatment. The Plan will assist in coordinating your care so that the treatment is received in the most appropriate

setting for your condition and that you receive the highest level of Benefits under the Plan. If you do not call for Preauthorization before receiving non-emergency services, Benefits for Covered Services may be subject to a reduction in Benefits, as set forth below.

For Preauthorization requests related to Urgent Care or Emergency Care, the Covered Person should refer to the Preauthorization procedures outlined below in this “*Preauthorization/Precertification*” section.

- **Preauthorization Process for Services Related to Treatment of Autism and Autism Spectrum Disorders**

The Preauthorization process described above shall also be applicable to the limited Benefits set forth in the section entitled, “Services Related to Treatment of Autism and Autism Spectrum Disorders.” However, covered Therapy Services (Physical Therapy, Occupational Therapy and Speech Therapy) do not require Preauthorization.

- **Preauthorization Process for Other Outpatient Services**

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

- **Preauthorization Requests Involving Non-Urgent Care**

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

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

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

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

- **Preauthorization Requests Involving Urgent Care/Expedited Clinical Claims**

A “Preauthorization Request Involving Urgent Care/Expedited Clinical Claims” 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 Covered Person or the ability of the Covered Person to regain maximum function; or
- in the opinion of a Physician with knowledge of the Covered Person’s medical condition, would subject the Covered Person 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/Expedited Clinical Claims,” the Claims Administrator will respond to you no later than 72 hours after receipt of the request, unless you fail to provide sufficient information to determine whether, or to what extent, Benefits are covered or payable under the Plan. In the case of such a failure, the Claims Administrator will notify you no later than 24 hours after receipt of your request, of the specific information necessary to complete your Preauthorization request. You will be given a minimum of 48 hours to provide the specified information. You will be notified of the Claims Administrator’s response to your Preauthorization request no later than 48 hours after the earlier of:

- the Claims Administrator’s receipt of the specified information; or
- the end of the 48–hour period you were given to provide the specified information.

NOTE: The Claims Administrator’s response to your Preauthorization Request Involving Urgent Care/Expedited Clinical Claims, including an adverse determination, if applicable, may be issued orally. A written notice will also be provided within three days following the oral notification.

- **Preauthorization Requests Involving Emergency Care**

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

- **Failure to Preauthorize**

If you do not call for Preauthorization for **Inpatient services or treatment**, the admission will be subject to a \$500 reduction in Benefits, if upon receipt of the claim, it is determined that the services were Medically Necessary. If it is determined that the services were not Medically Necessary or were Experimental/Investigational, it may be the Covered Person’s responsibility to pay the full cost of the services received.

If the Covered Person fails to obtain Preauthorization for **Outpatient services or treatment** for Mental Illness (including severe Mental Illness), drug abuse, substance abuse, alcoholism, or autism/autism spectrum disorders:

- The Claims Administrator will review the Medical Necessity of the treatment or service prior to the final Benefit determination.
- If the Claims Administrator determines the treatment or service is not Medically Necessary or is Experimental/Investigational, Benefits will be reduce or denied.

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

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

CONCURRENT REVIEW

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

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

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

WHAT TO DO IN AN EMERGENCY

- In the case of an emergency, when you get immediate medical assistance from a Hospital, Physician or other Provider that best meets the needs of your emergency, those Covered Services will receive the maximum allowable Benefits based upon the Allowable Charge for those services. If you use an Out-of-Network Provider for your Emergency Care, you will not be subject to the higher of Coinsurance amount nor the Out-of-Network Hospital Deductible normally associated with your use of an Out-of-Network Provider.
- It should be noted here that simply because care or treatment is received in an emergency department, it does not automatically qualify for Emergency Care. Emergency Care is defined as treatment for an injury, illness or condition manifesting itself by acute symptoms or sufficient severity, including severe pain, such that a reasonable and prudent layperson could expect the absence of medical attention to result in:
 - serious jeopardy to the Covered Person's health;
 - serious impairment to bodily function; or
 - serious dysfunction of any bodily organ or part.

ALLOWABLE CHARGE

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

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

REMEMBER ...

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

The Claims Administrator uses the following method of determining the Allowable Charge for Providers who do not have a Participating Provider agreement with the Claims Administrator (Non-Contracting Providers):

- The Allowable Charge for Non-Contracting Providers for Covered Services will be the lesser of:
 - the Provider’s billed charges; or
 - the Claims Administrator’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 Claims Administrator. 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 Claims Administrator and updated on a periodic basis. Such factor shall not be less than 100% of the average contract rate and will be updated not less than every two years. The Claims Administrator will utilize the same claim processing rules and/or edits that it utilizes in processing Participating Provider claims for processing claims submitted by Non-Contracting Providers which may also alter the Allowable Charge for a particular service. In the event the Claims Administrator does not have any claim edits or rules, the Claims Administrator 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 Claims Administrator within 145 days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

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

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

- the median amount negotiated with network or contracting Providers for the Emergency Care Services furnished;
- the amount for the Emergency Care Services calculated using the same method the Plan generally uses to determine payments for Out-of-Network Provider services, but substituting the in-network or contracting cost-sharing provisions for the out-of-network or non-contracting Provider cost sharing provisions; or
- the amount that would be paid under Medicare for the Emergency Care Services.

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

- 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.

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

- Charges for any services which are not covered under the Plan.
- Any Deductible or Coinsurance amounts that are applicable to your coverage (*including the higher Coinsurance amounts which apply to Out-of-Network Provider services*).
- The difference, if any, between your Provider’s billed charges and the Allowable Charge determined by the Host Plan.

SPECIAL NOTICES

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

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

Be sure to check for a “special notice”. It changes provisions or Benefits in the Plan.

IDENTIFICATION CARD

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

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

Carry your card at all times. If you lose your card, you can still use your coverage. You can replace your card faster, however, if you know your identification number.

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

DESIGNATING AN AUTHORIZED REPRESENTATIVE

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

QUESTIONS

Whenever you call the Claims Administrator’s 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 benefit booklet. If you need more help, please call a Customer Service Representative at 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 Covered Person identification number which is on your Identification Card. If the question involves a claim, be sure to give:

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

Eligibility, Enrollment, Changes & Termination

This section tells:

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

WHO IS AN ELIGIBLE PERSON

Eligibility Requirements for Participant Coverage: A person is eligible for Participant coverage from the first day that he or she is:

- a full-time, active Participant of the Plan Sponsor. A Participant is considered to be full-time if he or she normally works at least 30 hours per week, is on the regular payroll of the Plan Sponsor and works at least six months per year.
- in a class eligible for coverage:
 - Ministers who are members of the Oklahoma Conference (elders, associate, and probationary), full-time local pastors under appointment and enrolled in the Ministerial Pension Plan, or ordained ministers appointed under the provisions of Par. 346.1 or 346.2 of the 2004 Book of Discipline and their eligible Dependents. Those clergy members who have earned health insurance through military retirement or other government agencies may request approval from the Board of Pension to opt out of the Conference Healthcare Benefits. Decisions made on a case-by-case basis. Also, Deacons (full and probationary) employed and enrolled in either the Cumulative Pension and Benefit Program or the Ministerial Pension Plan and their eligible dependents. Also, a member appointed to attend school or one who receives his/her first appointment with pension benefit after having a special appointment without pension benefit and their eligible dependents.
 - Diaconal Ministers under appointment serving at least 30 hours a week in local churches, institutions or agencies of the Conference qualify for enrollment as Lay Participants.
 - Clergy couples qualified for enrollment as ministers must decide which one will Enroll as the primary participant carrying medical insurance for all Dependents, including the spouse. *If both are licensed local pastors or ordained and serving full-time under appointment in the Oklahoma Conference both shall be enrolled in the Life Insurance portion with \$50,000 death benefits; however, the spouse who is covered as the dependent will not be eligible to collect the dependent life insurance amount in addition to the clergy benefit.* The premium rate for a clergy couple is based on the total compensation of the higher paid minister.
 - Ministers appointed as “Less Than Full-Time” and all student or part-time local pastors who are enrolled in the ministerial pension plan and certified by their district superintendent as living on the charge and working a minimum of 30 hours per week on their pastoral duties may enroll, provided they are licensed, ordained or serving under the provision of Par. 346.1 or 346.2 of the 2004 Book of Discipline.

- Retired Ministerial Members of this Conference, age 62 or older and not eligible for Medicare benefits or with at least 35 years of service in The United Methodist Church, and their Eligible Dependents, who have been enrolled in the Minister’s Healthcare Benefit Plan for five years immediately prior to retirement may continue as Participants in the group for five years immediately prior to retirement may continue in the Plan for up to 18 months at the lay rate.
- Surviving spouses who are Participants in the Oklahoma United Methodist Healthcare Benefits at the time of the death of their spouse are eligible for continuous coverage in the Plan. A surviving spouse may maintain coverage in the Plan, unless they obtain medical coverage from another provider.
- Full-time Lay Participants of a local church, institution or agency of this Conference certified by their executive officer to the Conference Treasurer’s Office as working 30 hours a week and as making at least the minimum wage per hour may Enroll in the Medical Plan.
- Retired Lay Participants of a local church, or an institution or agency of this Conference which sponsor this Plan for Lay Participants. In order for a retired Lay Participant, and their eligible Dependents, to be eligible to participate they must be at least age 60 with ten or more continuous years of service in The Oklahoma United Methodist Church and five or more years of continuous participation in the Conference Healthcare Benefits.
- Divorced spouses who are Participants in the Oklahoma Healthcare Benefits are eligible for continuous coverage in the Plan at the Lay Participant rates until (a) they obtain medical coverage from another provider, or (b) they remarry, or (c) two years have elapsed following the date of the divorce, whichever occurs first. If the divorced spouse is totally and permanently disabled/incapacitated at the time of the divorce, coverage will be continued indefinitely beyond the two year period provided such spouse remains totally disabled/incapacitated, does not remarry, or obtain group coverage elsewhere. This will be subject to an annual review.

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

WHO IS AN ELIGIBLE DEPENDENT

An Eligible Dependent is defined as:

- your spouse.
- your common law spouse. An affidavit is required.
- any Dependent child. “Dependent child”, used hereafter, means a natural child, a stepchild, an adopted child or a child Placed for Adoption (including a child for whom you or your 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 or any combination of those factors. A child not listed above who is legally and financially dependent upon you or your spouse is also considered a Dependent child, provided proof of dependency is provided with the child’s application.

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

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

HOW TO ENROLL

To be covered under the Plan, you must complete the enrollment process outlined by your Human Resources Department.

INITIAL ENROLLMENT PERIOD

- **Initial Group Enrollment**

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

- **Initial Enrollment After the Plan Effective Date**

If you become an Eligible Person after the Plan Effective Date and your application is received within 31 days of being first eligible, the Effective Date for you and your Eligible Dependents (if applicable) will be the date you become eligible.

- **Initial Enrollment of New Dependents**

You can apply to add Dependents to your coverage by submitting an application within 31 days after you acquire an Eligible Dependent (see exceptions below for newborn children). The Effective Date for the Eligible Dependent will be the date the Dependent was acquired.

— **Newborn Children**

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

- If you are enrolled under Participant Only (Single) Coverage, you may add coverage for a newborn effective on the date of birth. However, your application must be received within 31 days of the child's birth.
- If you are enrolled under Participant and Spouse Only Coverage (if applicable), coverage for the newborn will be effective on the date of birth and continue for 31 days. In order to extend the coverage beyond 31 days, your application must be received within 31 days of the child's birth.
- If you are enrolled under Participant and Children Coverage or Participant, Spouse and Children Coverage (Family Coverage), no application will be required to add coverage for a newborn child. However, you must notify the Plan Administrator in writing of the child's birth within 31 days. The Effective Date for the newborn will be the child's birth date.
- If you choose not to Enroll your newborn child, coverage for that child will be included under the mother's maternity Benefits (provided the mother is enrolled under this Plan) for 48 hours following a vaginal delivery, or 96 hours following a cesarean section.

IMPORTANT:

To expedite the handling of your newborn's claims, please make sure your application (including your child's name and birth date) is received within 31 days of the child's birth.

— **Adopted Children**

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

Subject to the Exclusions, conditions and limitations of this benefit booklet, coverage for an adopted child will include the actual and documented medical costs associated with the birth of an adopted child who is 18

months of age or younger. You must provide copies of the medical bills and records associated with the birth of the adopted child and proof that you have paid or are responsible for payment of the medical bills associated with the birth and that the cost of the birth was not covered by another health care plan, including Medicaid.

SPECIAL ENROLLMENT PERIODS

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

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

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

- You and/or your Dependent must otherwise be eligible for coverage under the terms of the Plan.
- When the coverage was previously declined, you and/or your Dependent must have been covered under another Group Health Plan or must have had other health insurance coverage.
- When you declined enrollment for yourself or for your Dependent(s), you stated in writing that coverage under another Group Health Plan or other health insurance coverage was the reason for declining enrollment. This paragraph applies only if:
 - the Plan required such a statement when you declined enrollment; and
 - you are provided with notice of the requirement to provide the statement in this paragraph (and the consequences of your failure to provide the statement) at the time you declined enrollment.
- When you declined enrollment for yourself or for your Dependent under the Plan:
 - you and/or your Dependent had COBRA Continuation Coverage under another plan and COBRA Continuation Coverage under that other plan has since been exhausted; or
 - if the other coverage that applied to you and/or your Dependent when enrollment was declined was not under a COBRA continuation provision, either the other coverage has been terminated as a result of loss of eligibility for the coverage or Plan Sponsor contributions towards the other coverage have been terminated.

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

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

- **Special Enrollment For New Dependents**

A Special Enrollment Period occurs if a person has a new Dependent by birth, marriage, adoption, or Placement for Adoption. Your application must be received within 31 days following the birth, marriage, adoption, or Placement for Adoption. To Enroll an adopted child, a copy of the court order or adoption papers must accompany the application or change form. Special enrollment rules provide that:

- You may Enroll when you marry or have a new child (as a result of marriage, birth, adoption, or Placement for Adoption).
- Your spouse can be enrolled separately at the time of marriage or when a child is born, adopted, or Placed for Adoption.
- Your spouse can be enrolled together with you when you marry or when a child is born, adopted, or Placed for Adoption.
- A child who becomes your Dependent as a result of marriage, birth, adoption, or Placement for Adoption can be enrolled when the child becomes a Dependent.
- Similarly, a child who becomes your Dependent as a result of marriage, birth, adoption, or Placement for Adoption can be enrolled if you Enroll at the same time.
- Coverage with respect to a marriage is effective on the marriage date.
- Coverage with respect to a birth, adoption, or Placement for Adoption is effective on the date of the birth, adoption, or Placement for Adoption.

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

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

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

A 60–day Special Enrollment Period occurs when Participants and Dependents who are eligible but not enrolled for coverage in the Group Health Plan experience either of the following qualifying events:

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

An Participant must request this special enrollment into the Group Health Plan within 60 days of the loss of Medicaid or CHIP coverage, and within 60 days of the Participant or Dependent becoming eligible for a Group Health Plan premium assistance subsidy under Medicaid or CHIP. Coverage under special enrollment will be effective no later than the first day of the month after the Plan receives the special enrollment request.

OPEN ENROLLMENT PERIOD

If you do not Enroll for coverage for yourself or for your Eligible Dependent(s) during the Initial Enrollment Period or during a Special Enrollment Period, you may apply for coverage during the next Open Enrollment Period. An Open Enrollment Period will be held each year during the 31–days immediately before the Plan anniversary date (renewal date). Your application for coverage must be received by the Plan Administrator within this time period.

Individuals who Enroll during an Open Enrollment Period will be considered Late Enrollees under the Plan and will be subject to an 18-month Preexisting Condition Exclusion period. However, the 18-month Preexisting Condition Exclusion period will be reduced by the days of prior Creditable Coverage in effect before your and/or your Dependent's application was received by the Plan.

QUALIFIED COURT ORDERS FOR MEDICAL COVERAGE FOR DEPENDENT CHILDREN

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

The order must include specific information such as:

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

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

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

DELAYED EFFECTIVE DATE

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

This provision will not apply if you were absent from work due to a health status factor; or enrolled under the Plan Sponsor's Group Health Plan in force immediately before the Effective Date of this Plan.

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

DELETING A DEPENDENT

You can change your coverage to delete Dependents. The change will be effective at the end of the coverage period during which your contributions have been paid.

CONTINUATION DURING PERIODS OF PLAN SPONSOR-CERTIFIED DISABILITY, LEAVE OF ABSENCE OR SABBATICAL LEAVE.

A person may remain Eligible for a limited time if active, full-time work ceases due to disability, leave of absence or Sabbatical leave. This continuance will end as follows:

- **For Lay Participants Disability Leave Only:** The end of the 90–day period that next follows the month in which the person last worked as an active Participant.
- **For Ministers Incapacity/Disability Leave Only:** Insurance coverage will continue uninterrupted, provided such minister has been a participant in the plan prior to going on Incapacity/Disability Leave.
- **For Lay Participants Leave of Absence Only:** The end of the 90–day period that next follows the month in which the person last worked as an active Participant.
- **For Ministers Leave of Absence or If Placed on Leave of Absence Only:** When a minister is on a Leave of Absence he/she may continue in the plan up to an 18–month period that next follows the month in which the person last worked as a Minister at the lay rate.
- **For Ministers Sabbatical Leave:** When a minister is granted a sabbatical leave or is appointed to attend school his/her insurance coverage may continue until such time that he/she returns to the Ministry.
- **Continuation During Family and Medical Leave:** Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Plan Sponsor will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Participant had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Participant and his or her covered Dependents of the Participant returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Pre-Existing Conditions limitations and other Waiting Periods will not be imposed unless they were in effect for the Participant and/or his or her Dependents when Plan coverage terminated.

- **Rehiring a Terminated Participant.** A terminated Participant who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements.
- **Rehiring on Military Leave.** Participants going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to Participants and their Dependents covered under the Plan immediately before leaving for military services.
 - The maximum period of coverage of a person and the person’s Dependents under such an election shall be the lesser of:
 - The 24–month period beginning on the date on which the person’s absence begins; or
 - The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.
 - An exclusion may not be imposed in connection with the reinstated of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion may be imposed for coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been Incurred in, or aggravated during, the performance of uniformed service.

WHEN DEPENDENT COVERAGE TERMINATES

A Dependent’s coverage will terminate on the earliest of these dates:

- The date the Plan or Dependent coverage under the Plan is terminated.
- The date that the Participant's coverage under the Plan is terminates for any reason including death.
- The date a covered Spouse loses coverage due to loss of dependency status.
- On the last day of the calendar month that a Dependent child ceases to be a Dependent as defined by the Plan.
- The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

WHEN COVERAGE UNDER THIS PLAN ENDS

Coverage will stop at the end of the month in which an individual ceases to meet the definition of an Eligible Person or Eligible Dependent.

Participant coverage will terminate on the earliest of these dates:

- The date the Plan is terminated.
- The date the covered Participant's Eligible Class is eliminated.
- The last day of the calendar month in which the covered Participant ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Participant.
- The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

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

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

CERTIFICATES OF COVERAGE

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

- **Qualified Beneficiaries Upon a Qualifying Event**

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

- **Other Individuals When Coverage Ceases**

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

- **Qualified Beneficiaries When COBRA Ceases**

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

- **Any Individual Upon Request**

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

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

Schedule of Benefits

Comprehensive Health Care Services

This section shows how much the Plan pays for Covered Services described in the *Comprehensive Health Care Services* section that follows. It also explains the Copayment or Deductible you must pay before the Plan starts to pay for most Covered Services. **Please note that services must be Medically Necessary in order to be covered under the Plan.**

BENEFIT PERIOD

Calendar Year

OFFICE VISIT COPAYMENT

\$30 for each visit to a Physician's office or Urgent Care (Outpatient Services) Facility. The Copayment applies to charges which are billed as part of your Physician's office or Urgent Care Facility visit. The Copayment will also apply to laboratory and x-ray services performed at a BlueChoice PPO, BlueCard PPO or Out-of-Network Provider in conjunction with a covered office visit.

EXCEPTION: The office visit Copayment does not apply to the following services, which (except for covered childhood immunizations) are subject to the Deductible and Coinsurance provisions of your coverage:

- Surgical services;
- Physical Therapy and Occupational Therapy;
- Allergy testing and allergy injections;
- Covered immunizations;
- Durable Medical Equipment;
- Outpatient Diagnostics (including MRI, CAT Scan, PET Scan and Diagnostic Medical procedures).

OUTPATIENT THERAPY COPAYMENT

\$30 for each visit to a BlueChoice PPO, BlueCard PPO or Out-of-Network Provider for Outpatient Therapy Services (Physical, Occupational and Speech).

Copayments do not count toward the Deductible or Out-of-Pocket Limit under the Plan. In addition, the Copayment will continue to apply to charges Incurred after the Deductible and/or Out-of-Pocket Limit has been reached.

DEDUCTIBLE

BlueChoice PPO or BlueCard PPO Provider Services Deductible \$1,250 per Benefit Period per Covered Person. This Deductible applies to Covered Services received from a BlueChoice PPO or BlueCard PPO Provider. If the Covered Person has Incurred expenses which were applied toward his or her Out-of-Network Provider Services Deductible during the Benefit Period, those expenses will also count toward satisfaction of his or her Deductible amount for BlueChoice PPO or BlueCard PPO Provider Service.

Out-of-Network Provider Services Deductible \$2,500 per Benefit Period per Covered Person. This Deductible applies whenever the Covered Person receives Covered Services from a Provider who is not a member of the BlueChoice PPO or BlueCard PPO Provider network. If the Covered Person has Incurred expenses which were applied toward his or her BlueChoice PPO or BlueCard PPO Provider Services Deductible during the Benefit Period, those expenses will also count toward satisfaction of his or her Deductible amount for Out-of-Network Provider Services.

Covered Services *Not* Subject to Benefit Period Deductible The Benefit Period Deductible applies to all Covered Services, except:

- Routine Nursery Care.
- Preventive Care Services.
- Physician or Urgent Care services which are subject to the office visit Copayment.
- Outpatient Therapy Services (Physical, Occupational and Speech).
- Wigs and other scalp prostheses.

FAMILY DEDUCTIBLE

If your coverage includes your Dependents, then:

BlueChoice PPO or BlueCard PPO Provider Services Deductible • \$3,750 per Benefit Period per Covered Person. This Deductible applies to Covered Services received from a BlueChoice PPO or BlueCard PPO Provider. If the Covered Person has Incurred expenses which were applied toward his or her Out-of-Network Provider Services Deductible during the Benefit Period, those expenses will also count toward satisfaction of his or her Deductible amount for BlueChoice PPO or BlueCard PPO Provider Service.

Out-of-Network Provider Services Deductible • \$7,500 per Benefit Period per Covered Person. This Deductible applies whenever the Covered Person receives Covered Services from a Provider who is not a member of the BlueChoice PPO or BlueCard PPO Provider network. If the Covered Person has Incurred expenses which were applied toward his or her BlueChoice PPO or BlueCard PPO Provider Services Deductible during the Benefit Period, those expenses will also count toward satisfaction of his or her Deductible amount for Out-of-Network Provider Services.

- if two or more Covered Persons 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 Covered Person will contribute more than the individual Deductible amount.

The Family Deductible provisions described above apply only to the Benefit Period Deductible and do not include any other Deductible applicable to your coverage.

OUT-OF-POCKET LIMIT

- **BlueChoice PPO and BlueCard PPO Provider Services** — When you have paid \$2,400 (in excess of any Copayment and/or the Deductible amounts) for Covered Services provided by BlueChoice PPO and BlueCard 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 for Covered Services you receive from network Providers.
- **Out-of-Network Provider Services** — When you have paid \$4,800 (in excess of any Copayment and/or Deductible amounts) 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 Provider services.

The Out-of-Pocket Limit and Benefit percentage amount specified above do not apply to expenses Incurred for:

- Physician and Urgent Care Services which are subject to the office visit Copayment.
- Outpatient Therapy Services (Physical, Occupational and Speech) which are subject to the Outpatient Therapy Copayment.
- Charges in excess of the Allowable Charge.

FAMILY OUT-OF-POCKET LIMIT

- **BlueChoice PPO and BlueCard PPO Provider Services** — When you and your Dependents have paid \$7,200 (in excess of any Copayment and/or Deductible amounts) for Covered Services provided by BlueChoice PPO and BlueCard PPO Providers during a Benefit Period, the amount of Allowable Charges covered by the Plan on behalf of you and your Dependents will increase to 100% during the remainder of the Benefit Period for Covered Services received from network Providers.
- **Out-of-Network Provider Services** — When you and your Dependents have paid \$14,400 (in excess of any Copayment and/or Deductible amounts) for Covered Services provided by Out-of-Network Providers during a Benefit Period, the amount of Allowable Charges covered by the Plan on behalf of you and your Dependents will increase to 100% during the remainder of the Benefit Period for Out-of-Network Provider services.

MAXIMUM

Unlimited per lifetime per Covered Person.

BENEFIT PERCENTAGE

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

COVERED SERVICES (Subject to the <i>Comprehensive Health Care Services</i> section which follows)	BENEFIT PERCENTAGE AMOUNT:	
	BlueChoice PPO & BlueCard PPO Provider Services	Out-of-Network Provider Services
PREVENTIVE CARE SERVICES		
Covered Immunizations	100%	100%
Routine Low-Dose Mammography	100%	100%
All Other Covered Preventive Care Services	100%	100%
EMERGENCY CARE SERVICES¹	80%	80%

THE FOLLOWING BENEFIT PERCENTAGES APPLY TO SERVICES THAT ARE NOT CLASSIFIED AS PREVENTIVE CARE SERVICES OR EMERGENCY CARE SERVICES, AS DETERMINED BY THE PLAN

HOSPITAL SERVICES²	80%	60%
SURGICAL/MEDICAL SERVICES		
Physicians' Office Visits	100% ³	100% ³
All Other Covered Surgical/Medical Services	80%	60%
OUTPATIENT DIAGNOSTIC SERVICES	80%	60%
OUTPATIENT THERAPY SERVICES	100%	100%
MATERNITY SERVICES	80%	60%
MASTECTOMY AND RECONSTRUCTIVE SURGICAL SERVICES	80%	60%
HUMAN ORGAN, TISSUE AND BONE MARROW TRANSPLANT SERVICES	80%	60%
AMBULATORY SURGICAL FACILITY SERVICES	80%	60%

¹ Non-emergency use of the Emergency Room is subject to a \$75 Deductible, then Benefit Period Deductible and Coinsurance apply.

² Inpatient Hospital Services are subject to Preauthorization approval from the Plan. See the "Important Information" section of this Plan Summary for details regarding Preauthorization requirements.

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

COVERED SERVICES (Subject to the <i>Comprehensive Health Care Services</i> section which follows)	BENEFIT PERCENTAGE AMOUNT:	
	<u>BlueChoice PPO & BlueCard PPO Provider Services</u>	<u>Out-of-Network Provider Services</u>
SERVICES RELATED TO TREATMENT OF AUTISM AND AUTISM SPECTRUM DISORDERS	80%	60%
PSYCHIATRIC CARE SERVICES	80%	60%
AMBULANCE SERVICES	80%	80%
PRIVATE DUTY NURSING SERVICES	80%	60%
REHABILITATION CARE	80%	60%
SKILLED NURSING FACILITY SERVICES	80%	60%
HOME HEALTH CARE SERVICES	80%	60%
HOSPICE SERVICES	80%	60%
ALL OTHER COVERED SERVICES	80%	60%

Comprehensive Health Care Services

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

PREVENTIVE CARE SERVICES

NOTE: Preventive Care Services received from BlueChoice PPO and BlueCard PPO Providers are not subject to Deductible, Copayment, Coinsurance or dollar maximum.

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

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

The Preventive Care Services described above may change as the USPSTF, CDC and HRSA guidelines are modified. For more information Covered Persons may access the Web site at www.bcbsok.com or contact customer services at the toll-free number listed on their Identification Card.

Examples of Covered Services included are routine annual physicals, immunizations, well-child care, cancer screening mammograms, bone density testing, screening for prostate cancer and colorectal cancer, smoking cessation counseling services, healthy diet counseling and obesity screening/counseling.

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

Covered Services *not* included in the items listed above *may* be subject to Coinsurance, Deductible and/or dollar maximums.

EMERGENCY CARE SERVICES

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

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

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

HOSPITAL SERVICES

The Plan pays the scheduled amounts for the following Covered Services you receive from a Hospital or other Provider.

- **Bed and Board**

Bed, board and general nursing service in:

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

Inpatient services are subject to the Preauthorization guidelines of the Plan (see "Important Information"). If you fail to comply with these guidelines, Benefits for Covered Services rendered during your Inpatient confinement will be reduced by \$500, as described under "Failure to Preauthorize," provided the Claims Administrator determines that Benefits are payable upon receipt of a claim.

- **Ancillary Services**

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

- **Emergency Accident Care**

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

- **Emergency Medical Care**

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

- **Surgery**

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

- **Routine Nursery Care**

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

— 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 the Plan:

- the infant will be considered as a Covered Person in its own right and will be entitled to the same Benefits as any other Covered Person under the Plan; and
- a separate Deductible will apply to the newborn's Hospital confinement.

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

SURGICAL/MEDICAL SERVICES

The Plan pays the scheduled amounts for the following Covered Services you receive from a Physician or other Provider.

- **Surgery**

Payment includes visits before and after Surgery.

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

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

- the primary procedure; plus
- 50% of the amount payable for each of the additional procedures had those procedures been performed alone.

— Sterilization, regardless of Medical Necessity.

— Weight Loss Surgery

- Benefits for Weight Loss Surgery is covered when services are Medically Necessary and the Covered Person has been diagnosed as morbidly obese.
- **Benefits for Weight Loss Surgery are limited to one Surgery per lifetime per Covered Person (unless additional surgeries are Medically Necessary). Follow-up care will be paid at the regular Benefit level.**

*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.

— Oral Surgery

Oral surgery for surgical removal of complete bony and/or partially impacted teeth.

- **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 Claims Administrator.

- **Anesthesia**

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

- **Inpatient Medical Services**

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

— Inpatient Medical Care Visits

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

— Intensive Medical Care

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

— Concurrent Care

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

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

— Consultation

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

— Newborn Well Baby Care

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

- **Outpatient Medical Services**

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

— Emergency Accident Care

Treatment of accidental bodily injuries.

— Emergency Medical Care

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

— Home, Office, and Other Outpatient Visits

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

— Contraceptive Devices

Contraceptive devices which are:

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

— Audiological Services

Audiological services and hearing aids for Covered Persons up to age 18 are limited to:

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

Audiometric examinations, hearing aid evaluations, conformity evaluations and hearing aids are limited to **one hearing aid and mold per ear every five years for Covered Persons over age 18.**

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

— Muscle Manipulation and Spinal Subluxation

Muscle manipulation and spinal subluxation when administered by a Chiropractor. **Benefits are limited to a maximum of 25 visits per Benefit Period per Covered Person.**

OUTPATIENT DIAGNOSTIC SERVICES

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

OUTPATIENT THERAPY SERVICES

- Radiation Therapy
- Chemotherapy

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 Plan.

- Respiratory Therapy
- Dialysis Treatment
- Physical Therapy

Benefits for Outpatient Physical Therapy (including visits to the Covered Person's home) are limited to a maximum of 60 visits per Benefit Period per Covered Person.

- Occupational Therapy

Benefits for Outpatient Occupational Therapy (including visits to the Covered Person's home) are limited to a maximum of 60 visits per Benefit Period per Covered Person.

- Speech Therapy

Benefits for Outpatient Speech Therapy (including visits to the Covered Person's home) are limited to a maximum of 60 visits per Benefit Period per Covered Person.

MATERNITY SERVICES

- Hospital Services and Surgical/Medical Services from a Provider (including the services of midwives) to an Employee or the Employee's covered spouse for:

- Normal Pregnancy

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

- Complications of Pregnancy

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

- Interruptions of Pregnancy

- Miscarriage

- Abortion services are excluded for supplies, care or treatment in connection with an abortion unless the life of the mother is endangered by the continued Pregnancy or the Pregnancy is the result of rape or incest.

- Covered Maternity Services include the following:

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

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

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

- physical assessment of the mother and newborn infant;

- parent education regarding childhood immunizations;

- training or assistance with breast or bottle feeding; and

- performance of any Medically Necessary and appropriate clinical tests.

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

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

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

Maternity Services for Dependent children are not covered.

MASTECTOMY AND RECONSTRUCTIVE SURGICAL SERVICES

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

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

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

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

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

HUMAN ORGAN, TISSUE AND BONE MARROW TRANSPLANT SERVICES

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

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

• **DEFINITIONS**

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

— **Bone Marrow Transplant**

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

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

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

— **High-Dose Chemotherapy**

A form of Chemotherapy wherein the dose exceeds standard doses of Chemotherapy to the extent that virtually all patients who receive High-Dose Chemotherapy sustain destruction of the bone marrow to the

point that bone marrow or peripheral stem cells or progenitor cells must be implanted or infused to keep the patient alive.

— **High-Dose Radiation Therapy**

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

— **Preauthorization**

Authorization from the Claims Administrator that, based upon the information submitted by the Covered Person's attending Physician, Benefits will be provided under the Plan. Preauthorization is subject to all conditions, exclusions and limitations of the Plan. Preauthorization does not guarantee that all care and services a Covered Person receives are eligible for Benefits under the Plan.

— **Procurement Services**

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

• **TRANSPLANT SERVICES**

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

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

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

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

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

- **DONOR BENEFITS**

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

- When both the recipient and the living donor are Covered Persons, each is entitled to the Benefits of the Plan.
- When only the recipient is a Covered Person, both the donor and the recipient are entitled to the Benefits of the Plan. 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 Plan.
- When only the living donor is a Covered Person, the donor is entitled to the Benefits of the Plan. 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-Covered Person transplant recipient.
- If any organ or tissue or bone marrow or stem cells or progenitor cells are sold rather than donated to the Covered Person recipient, no Covered Services will be provided for the purchase price, evaluation, Procurement Services or procedure.
- The Plan is not liable for transplant expenses Incurred by donors, except as specifically provided.

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

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

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

AMBULATORY SURGICAL FACILITY SERVICES

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

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

SERVICES RELATED TO TREATMENT OF AUTISM AND AUTISM SPECTRUM DISORDERS

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

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

Speech Therapy, Physical Therapy and Occupational Therapy visits related to treatment of autism or autism spectrum disorders are not subject to the limitations specified under "*Outpatient Therapy Services*" as set forth in the *Comprehensive Health Care Services* section of the Plan.

Benefits related to treatment of autism and autism spectrum disorders are not subject to the Preexisting Condition Exclusion provisions of the Plan.

PSYCHIATRIC CARE SERVICES

The Plan pays the scheduled amounts for the following Covered Services you receive from a Provider to treat Mental Illness.

- Inpatient Facility Services

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

- Inpatient Medical Services

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

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

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

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

- Outpatient Psychiatric Care Services

- Facility and Medical Services

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

- Day/Night Psychiatric Care Services

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

- Drug Abuse and Alcoholism

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

AMBULANCE SERVICES

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

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

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

PRIVATE DUTY NURSING SERVICES

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

REHABILITATION CARE

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

Rehabilitation Care is limited to 180 days of Inpatient care per Benefit Period per Covered Person.

Rehabilitation Care is subject to the Preauthorization guidelines of the Plan (see “*Important Information*”). Failure to comply with these guidelines will result in a \$500 reduction in Benefits (as described under “*Failure to Preauthorize*”) for Rehabilitation Care if, upon receipt of a claim, Benefits are payable under the Plan.

SKILLED NURSING FACILITY SERVICES

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

Skilled Nursing Facility Services are limited to 60 days of Inpatient care per Benefit Period per Covered Person.

Skilled Nursing Facility Services are subject to the Preauthorization guidelines of the Plan (see “*Important Information*”). Failure to comply with these guidelines will result in a \$500 reduction in Benefits (as described under “*Failure to Preauthorize*”) for Skilled Nursing Facility Services if, upon receipt of a claim, Benefits are payable under the Plan.

No Benefits are payable:

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

HOME HEALTH CARE SERVICES

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

- Medical and surgical supplies;
- Prescribed drugs;
- Oxygen and its administration;
- **Up to 100 visits per Benefit Period per Covered Person, limited to the following:**
 - Professional services of an RN, LPN, or LVN;
 - Medical social service consultations;
 - Health aide services while you are receiving covered nursing or Therapy Services;

- Services of a licensed registered dietician or licensed certified nutritionist, when authorized by the patient’s supervising Physician and when Medically Necessary as part of diabetes self–management training.

Home Health Care is subject to the Preauthorization guidelines of the Plan (see “Important Information”). Failure to comply with these guidelines will result in a \$500 reduction in Benefits (as described under “Failure to Preauthorize”) for Home Health Care if, upon receipt of a claim, Benefits are payable under the Plan.

The Plan does not pay Home Health Care Benefits for:

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

HOSPICE SERVICES

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

Hospice Services are subject to the Preauthorization guidelines of the Plan (see “Important Information”). Failure to comply with these guidelines will result in a \$500 reduction in Benefits (as described under “Failure to Preauthorize”) for Hospice Services, if, upon receipt of a claim, Benefits are payable under the Plan.

DENTAL SERVICES FOR ACCIDENTAL INJURY

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

TEMPOROMANDIBULAR JOINT DYSFUNCTION

Treatment of temporomandibular joint dysfunction (TMJ) including, but not limited to, Surgery, 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 dysfunction or any other conditions involving the jaw joint, adjacent muscles or nerves, regardless of cause or diagnosis.

DIABETES EQUIPMENT, SUPPLIES AND SELF–MANAGEMENT SERVICES

- The following equipment, supplies and related services for the treatment of Type I, Type II, and gestational diabetes when Medically Necessary and when recommended or prescribed by a Physician or other Provider:
 - Blood glucose monitors;

- Blood glucose monitors to the legally blind;
- Test strips for glucose monitors;
- Visual reading and urine testing strips;
- Insulin;
- Injection aids;
- Cartridges for the legally blind;
- Syringes;
- Insulin pumps and appurtenances thereto;
- Insulin infusion devices;
- Oral agents for controlling blood sugar;
- Podiatric appliances for prevention of complications associated with diabetes; and
- Other diabetes equipment and related services that are determined Medically Necessary by the Oklahoma State Board of Health, provided such equipment and supplies have been approved by the federal Food and Drug Administration (FDA).

Coverage for the equipment, supplies and self-management services specified above shall be provided in accordance with the terms and conditions of the appropriate Benefit section of the Plan (for example: “Durable Medical Equipment” or “Home Health Care Services”).

DURABLE MEDICAL EQUIPMENT

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

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

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

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

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

PROSTHETIC APPLIANCES

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

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

ORTHOTIC DEVICES

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

Benefits will be provided for the following orthotic devices:

- Braces for the leg, arm, neck, back, or shoulder;
- Back and special surgical corsets;
- Splints for the extremities;
- Trusses;
- Orthopedic shoes when Medically Necessary for Covered Persons diagnosed with diabetes.

Not covered are:

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

WIGS OR OTHER SCALP PROSTHESES

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

Benefits are limited to two wigs per Benefit Period per Covered Person.

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

WHAT IS NOT COVERED

Except as otherwise specifically stated in the Plan, the Plan does not provide Benefits for services, supplies or charges:

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

- For cosmetic Surgery or complications resulting therefrom, including Surgery to improve or restore your appearance, unless:
 - needed to repair conditions resulting from an accidental injury; or
 - for the improvement of the physiological functioning of a malformed body member, except for services related to Orthognathic Surgery, osteotomy, or any other form of oral Surgery, dentistry, or dental processes to the teeth and surrounding tissue.

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

- Received from a member of your immediate family.
- Received before your Effective Date.
- For any Inpatient care and services, including rehabilitation care and services, unless documentation can be provided that, due to the nature of the services rendered or your condition, you cannot receive safe or adequate care as an Outpatient.
- Received after your coverage stops.
- For personal hygiene and convenience items regardless of whether or not recommended by a Physician or other Provider. Examples include: computers; air conditioners, air purifiers or filters; humidifiers; physical fitness equipment, including exercise bicycles or treadmills; or modifications to your home or vehicle.
- For telephone consultations, email or other electronic consultations, missed appointments, or completion of a claim form.
- For Custodial Care such as sitters' or homemakers' services, care in a place that serves you primarily as a residence when you do not require skilled nursing, or for rest cures.
- For foot care only to improve comfort or appearance such as care for flat feet, subluxation, corns, bunions (except capsular and bone Surgery), calluses, toenails, and the like.
- For routine, screening or periodic physical examinations, except as specified in the *Comprehensive Health Care Services* section.
- For reverse sterilization.
- For contraceptive medications or devices which are sold without a Physician's prescription (including condoms; contraceptive foam, sponges, or cream; or other spermicides).
- For abortion services unless the life of the mother is endangered by the continued Pregnancy or the Pregnancy is the result of rape or incest.
- For Orthognathic Surgery, osteotomy, or any other form of oral Surgery, dentistry, or dental processes to the teeth and surrounding tissue (including complications resulting therefrom), except for:
 - the treatment of accidental injury to the jaw, sound natural teeth, mouth or face; or
 - for the improvement of the physiological functioning of a malformed body member.

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

- For or related to Inpatient treatment of any non-covered dental procedure, except that coverage shall be provided for Hospital Services, Ambulatory Surgical Facility Services, and anesthesia services associated with any Medically Necessary dental procedure when provided to a Covered Person who is:
 - severely disabled; or
 - eight years of age or under;
 and who has a medical or emotional condition which requires hospitalization or general anesthesia for dental care.
- For eyeglasses, contact lenses or examinations for prescribing or fitting them, except for aphakic patients (including lenses required after cataract Surgery) and soft lenses or sclera shells to treat disease or injury. Vision examinations not related to the prescription or fitting of lenses will be a Covered Service only when performed in connection with the diagnosis or treatment of disease or injury. Eye refractions are not covered in any event.
- For eye Surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).
- For transsexual Surgery or any treatment leading to or in connection with transsexual Surgery.
- For diagnosis, treatment or medications for infertility and fertilization procedures. Examples include any form of: artificial insemination; ovulation induction procedures; in vitro fertilization; embryo transfer; or any other procedures, supplies or medications which in any way are intended to augment or enhance your reproductive ability.
- For treatment of sexual problems not caused by organic disease.
- For treatment of obesity, except as specified for morbid obesity in the *Comprehensive Health Care Services* section, regardless of the patient's history or diagnosis, including but not limited to the following: weight reduction or dietary control programs; surgical procedures; prescription or nonprescription drugs or medications such as vitamins (whether to be taken orally or by injection), minerals, appetite suppressants, or nutritional supplements; and any complications resulting from weight loss treatments or procedures.
- For drugs and medicines purchased by a Covered Person on an Outpatient basis, with or without a Physician's prescription, including drugs and medicines dispensed in the Physician's office, in the Outpatient department of a Hospital, or other Outpatient setting.
- For or related to acupuncture, whether for medical or anesthesia purposes.
- For conditions related hyperkinetic syndromes, learning disabilities, behavioral problems, mental retardation, or for Inpatient confinement for environmental change. This exclusion **shall not** apply to Physicians' services (except for neuropsychological testing) related to the diagnosis and treatment of attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD) for Covered Persons age 19 and under, which are Medically Necessary services.
- For unspecified developmental disorders or autistic disease, except as specified under "*Services Related to Treatment of Autism and Autism Spectrum Disorders.*"
- For or related to applied behavior analysis.
- For hippotherapy, equine assisted learning, or other therapeutic riding programs.
- For which the Provider of service customarily makes no direct charge to a Covered Person.
- Received from a Skilled Nursing Facility, Home Health Care Agency, Hospice, or rehabilitation facility which is not a Plan-approved Provider.

- For or related to transplantation of donor organs, tissues or bone marrow, except as specified under “*Human Organ, Tissue and Bone Marrow Transplant Services*”.
- For Physician standby services.
- For Continuous Passive Motion (CPM) devices used in treatment of the shoulder or other joints, except for up to 21 days postoperatively for the following surgical procedures: total knee arthroplasty, anterior cruciate ligament reconstruction, or open reduction and internal fixation of tibial plateau for distal femur fractures involving the knee joint.
- For ductal lavage of the mammary ducts.
- For extracorporeal shock wave treatment, also known as orthotripsy, using either a high- or low-dose protocol, for treatment of plantar fasciitis and all other musculoskeletal conditions.
- For orthoptic training.
- For thermal capsulorrhaphy as a treatment of joint instability, including but not limited to instability of shoulders, knees and elbows.
- For transcutaneous electrical nerve stimulator (TENS).
- For Inpatient drug and alcohol treatment that is not rendered by a Hospital, Psychiatric Hospital, Residential Treatment Center or other Plan-approved Provider.
- For massage therapy, including but not limited to effleurage, petrissage and/or tapotement.
- Which are not specifically named as Covered Services subject to any other specific Exclusions and limitations in this benefit booklet.

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 the Plan has allowed for Benefits. You must provide to us all documents needed to enforce our rights under this provision.

PREEXISTING CONDITION EXCLUSION

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

- **Three-month Look-back Rule**
 - The Preexisting Condition Exclusion must relate to a condition (whether physical or mental, and regardless of the cause of the condition) for which medical advice, diagnosis, care, or treatment was recommended or received within the three-month period ending on the Covered Person’s Enrollment Date.
 - In order to be taken into account, the medical advice, diagnosis, care, or treatment must have been recommended or received from an individual licensed or similarly authorized to provide such services under state law and operating within the scope of practice authorized by state law.
 - The three-month look-back period is based on the three-month “anniversary date” of the Enrollment Date.
- **Length of Preexisting Condition Exclusion Period**

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

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

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

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

- **Elimination of Preexisting Condition Exclusion for Children**

The Preexisting Condition Exclusion provisions specified above do not apply to Covered Persons who are under age 19.

- **Notice to Covered Persons**

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

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

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

General Provisions

This section tells:

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

BENEFITS TO WHICH YOU ARE ENTITLED

The Plan provides only the Benefits specified in this benefit booklet.

Only Covered Persons are entitled to Benefits from the Plan and they may not transfer their rights to Benefits to anyone else.

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

PRIOR APPROVAL

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

NOTICE AND PROPERLY FILED CLAIM

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

Your Properly Filed Claim must be furnished to the Claims Administrator within one year from the date of service for which claim is made.

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

LIMITATION OF ACTIONS

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

PAYMENT OF BENEFITS

You authorize the Claims Administrator to make payments directly to Providers giving Covered Services for which the Plan provides Benefits under this benefit booklet. The Claims Administrator also reserves the right to make payments directly to you.

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

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

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

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 Claims Administrator. These Providers (called BlueTraditional Providers) have agreed to charge Plan Covered Persons no more than a “Maximum Reimbursement Allowance” for Covered Services. Covered Persons 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.

BENEFITS FOR SERVICES OUTSIDE THE STATE OF OKLAHOMA

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

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

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

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

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

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

DETERMINATION OF BENEFITS AND UTILIZATION REVIEW

The Claims Administrator, is hereby granted discretionary authority to interpret the terms and conditions of the Plan and to determine its Benefits.

In determining whether services or supplies are Covered Services, the Claims Administrator will determine whether a service or supply is Medically Necessary under the Plan or if such service or supply is Experimental or Investigational. The Claims Administrator's 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 Claims Administrator upon request and may be found on the Claims Administrator's Web site at www.bcbsok.com.

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

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

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

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

Failure of the Covered Person to comply with the Claims Administrator's request for medical records or medical evaluation may result in Benefits being partially or wholly denied.

COVERED PERSON/PROVIDER RELATIONSHIP

The choice of a Provider is solely yours.

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

The Claims Administrator does not furnish Covered Services but only pays for Covered Services you receive from Providers. They are not liable for any act or omission of any Provider. They have no responsibility for a Provider's failure or refusal to give Covered Services to you.

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

COORDINATION OF BENEFITS

All Benefits provided under this benefit booklet are subject to this provision.

- **Definitions**

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

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

- Group, blanket or franchise insurance coverage;
- Blue Cross Plan, Blue Shield Plan, Health Maintenance Organization, and other prepayment coverage;
- Coverage under labor–management trustee plans, union welfare plans, employer organization plans, or employee benefit organization plans;
- Coverage toward the cost of which any employer has contributed, or with respect to which any employer has made payroll deduction; and
- Coverage under any tax supported or government program to the extent permitted by law.

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

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

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

- **Effect On Benefits**

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

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

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

- **Order Of Benefit Determination**

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

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

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

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

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

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

- **Facility Of Payment**

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

- **Right Of Recovery**

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

PLAN'S RIGHT OF RECOUPMENT

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

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

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

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

LIMITATIONS ON PLAN'S RIGHT OF RECOUPMENT/RECOVERY

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

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

Claims Filing Procedures

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

PARTICIPATING PROVIDER NETWORKS

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

REMEMBER . . .

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

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 the Claims Administrator (whether in-state or out-of-state), you should pay the Hospital yourself and then file a claim for Covered Hospital Services.

AMBULATORY SURGICAL FACILITY CLAIMS

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

PHYSICIAN AND OTHER PROVIDER CLAIMS

If you are treated by a Physician or other Provider who does not have an agreement with the Claims Administrator, 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 the Claims Administrator subtracts your Deductible and/or Coinsurance amounts which apply to your coverage.

PARTICIPANT-FILED CLAIMS

When you must file a claim yourself, you may obtain claim forms by contacting the nearest Claims Administrator's office.

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

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

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

A separate claim form must be filled out for each Covered Person, 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, the Claims Administrator must receive your claims for Covered Services within one year from date of service for which claim is made.

BENEFIT DETERMINATIONS FOR PROPERLY FILED CLAIMS

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

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

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

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

DIRECT CLAIMS LINE

The Claims Administrator has a direct line for claims and membership inquiries. You may call 1-800-942-5837 between 8:00 a.m. and 5:00 p.m., Monday through Friday, whenever you have a question concerning a claim or your membership.

Complaint/Appeal Procedure

The Claims Administrator 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.

IF A CLAIM IS DENIED OR NOT PAID IN FULL

On occasion, the Claims Administrator 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 the Claims Administrator; then review this Benefit Booklet 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 the Claims Administrator and request a review of the decision. Include your full name, group and Covered Person's identification numbers with the request.

If a claim for Benefits is denied in whole or in part, you will receive a notice from the Claims Administrator within the following time limits:

- For non-urgent pre-service claims, within 15 days after receipt of the claim by the Claims Administrator. A "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.
- For post-service claims within 30 days after receipt of the claim by the Claims Administrator. A "Post-service claim" is notification in a form acceptable to the Claims Administrator that a service has been rendered or furnished to you. 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 the Claims Administrator may request in connection with services rendered to you.

If the Claims Administrator determines that special circumstances require an extension of time for processing the claim, for non-urgent pre-service and post-service claims, the Claims Administrator shall notify you or your authorized representative in writing of the need for extension, the reason for the extension, and the expected date of decision within the initial period. In no event shall such extension exceed 15 days from the end of such initial period. If an extension is necessary because additional information is needed from you, the notice of extension shall also specifically describe the missing information, and you shall have at least 45 days from the receipt of the notice within which to provide the requested information.

**The Plan has established procedures for you to designate an individual to act on your behalf with respect to a Benefit claim or an appeal of an adverse Benefit determination. A Provider or other health care professional with knowledge of your medical condition is permitted to act as your authorized representative or to bring an appeal on your behalf.*

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

- The reasons for determination;
 - A reference to the Group Health Plan 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 information 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), diagnosis, treatment and denial codes with their meanings and the standards used;
 - An explanation of the Claims Administrator’s internal review/appeals and external review processes (and how to initiate a review/appeal or external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on internal review/appeal;
 - In certain situations, a statement in non-English language(s) that future notices of claim denials and certain other benefit information may be available in such non-English language(s);
 - 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/Expedited Clinical Claim, a description of the expedited review procedure applicable to such claims. An Urgent Care/Expedited Clinical Claim decision may be provided orally, so long as a written notice is furnished to the claimant within three days of oral notification;
 - Contact information for applicable office of health insurance consumer assistance or ombudsman.
- For Benefit determinations relating to Urgent Care/Expedited Clinical Appeal (as defined below), such notice will be provided no later than 24 hours after the receipt of your claim for Benefits, unless you fail to provide sufficient information. You will be notified of the missing information and will have no less than 48 hours to provide the information. A Benefit determination will be made within 48 hours after the missing information is received.
 - For Benefit determinations relating to care that is being received at the same time as the determination, such notice will be provided no later than 24 hours after receipt of your claim for Benefits.

An “Urgent Care/Expedited Clinical Claim” is any pre-service claim for Benefits for Medical Care or treatment with respect to which the application of regular time period for making health claim decision 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.

CLAIM APPEAL PROCEDURES — DEFINITIONS

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 the Claims Administration at the number on the back of your Identification Card.

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 or Investigational or not Medically Necessary or appropriate. If an ongoing course of treatment had been approved by the Claims Administrator or your Plan Sponsor and the Claims Administrator or your Plan Sponsor reduces or terminates such treatment (other than by amendment or termination of the Plan Sponsor’s benefit plan) 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 Claims Administrator or your Plan Sponsor at the completion of the Claims Administrator’s or Plan Sponsor’s internal review/appeal process.

RIGHT TO REVIEW CLAIM DETERMINATIONS

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 the Claims Administrator in accordance with the Benefits and procedures detailed in your Group Health Plan.

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

- Within 180 days after you receive notice of a denial or partial denial, write to the Claims Administrator’s Administrative Office. The Claims Administrator 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

- You may also designate a representative to act for you in the review procedure. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative.
- The Claims Administrator 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 the Claims Administrator by phone or in person at a location of the Claims Administrator’s choice. 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.

The Claims Administrator 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. The appeal will be conducted by individuals associated with the Claims Administrator 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 the Claims Administrator or your Plan Sponsor.

- If you have any questions about the claims procedures or the review procedure, write to the Claims Administrator's Administrative Office or call the toll-free Customer Service number shown in this Benefit Booklet or on your Identification Card.

URGENT CARE/EXPEDITED CLINICAL APPEALS

If your situation meets the definition of an Urgent Care/Expedited Clinical Appeal, you may be entitled to an appeal on an expedited basis. An Urgent Care/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. Before authorization of Benefits for an ongoing course of treatment is terminated or reduced, the Claims Administrator 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 Urgent Care/Expedited pre-service or concurrent Clinical Appeal, the Claims Administrator 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 Claims Administrator shall render a determination on the appeal within 24 hours after it receives the requested information.

NOTICE OF APPEAL DETERMINATION

The Claims Administrator 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, orally of its determination followed-up 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 information about how to obtain diagnosis, treatment and denial codes with their meanings;
- An explanation of the Claims Administrator's external review processes (and how to initiate an external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on external appeal;
- In certain situations, a statement in non-English language(s) that future notices of claim denials and certain other benefit information may be available in such non-English language(s);
- 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.

If the Claim Administrator’s or your Plan Sponsor’s decision is to continue to deny or partially deny your claim or you do not receive timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision. Your external review rights are described in the “**Standard External Review**” section below.

IF YOU NEED ASSISTANCE

If you have any questions about the claims procedures or the review procedure, write or call the Claims Administrator Headquarters at 1-800-521-2227. The Claim Administrator Customer Service Helpline is accessible from 8:00 a.m. to 8:00 p.m., Monday through Friday.

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

If you need assistance with the internal claims and appeals or the external review processes that are described below, you may call the number on the back of your Identification Card for contact information. In addition, for questions about your appeal rights or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA*(3272).

STANDARD EXTERNAL REVIEW

You or your authorized representative (as described above) may make a request for a standard external review or expedited external review of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination by an independent review organization (IRO).

- **Request for external review.** Within 4 months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination from the Claims Administrator, you or your authorized representative must file your request for standard external review. If there is no corresponding date, four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.
- **Preliminary review.** Within five business days following the date of receipt of the external review request, the Claims Administrator must complete a preliminary review of the request to determine whether:
 - You are, or were, covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
 - The Adverse Benefit Determination or the Final Adverse Internal Benefit Determination does not relate to your failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);
 - You have exhausted the Claims Administrator’s internal appeal process unless you are not required to exhaust the internal appeals process under the interim final regulations. Please read the “**Exhaustion**” section below for additional information and exhaustion of the internal appeal process; and

- You or your authorized representative have provided all the information and forms required to process an external review.

You will be notified within one business day after the Claims Administrator completes the preliminary review if your request is eligible or if further information or documents are needed. You will have the remainder of the four-month appeal period (or 48 hours following receipt of the notice), whichever is later, to perfect the appeal request. If your claim is not eligible for external review, the Claims Administrator will outline the reasons it is ineligible in the notice, and provide contact information for the Department of Labor's Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).

- **Referral to Independent Review Organization.** When an eligible request for external review is completed within the time period allowed, the Claims Administrator will assign the matter to an independent review organization (IRO). The IRO assigned will be accredited by URAC or by similar nationally-recognized accrediting organization. Moreover, the Claims Administrator will take action against bias and to ensure independence. Accordingly, the Claims Administrator must contract with at least three IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of Benefits.

The IRO must provide the following:

- Utilization of legal experts where appropriate to make coverage determinations under the Plan.
- Timely notification to you or your authorized representative, in writing, of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within 10 business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.
- Within five business days after the date of assignment of the IRO, the Claims Administrator must provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Failure by the Claims Administrator to timely provide the documents and information must not delay the conduct of the external review. If the Claims Administrator fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Within one business day after making the decision, the IRO must notify the Claims Administrator and you or your authorized representative.
- Upon receipt of any information submitted by you or your authorized representative, the assigned IRO must within one business day forward the information to the Claims Administrator. Upon receipt of any such information, the Claims Administrator may reconsider the Adverse Benefit Determination or Final Internal Adverse Benefit Determination that is the subject of the external review. Reconsideration by the Claims Administrator must not delay the external review. The external review may be terminated as a result of the reconsideration only if the Claims Administrator decides, upon completion of its reconsideration, to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination and provide coverage or payment. Within one business day after making such a decision, the Claims Administrator must provide written notice of its decision to you and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the Claims Administrator.
- Review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Claims Administrator's internal claims and appeals process applicable under paragraph (b) of the interim final regulations under section 2719 of the Public Health Service (PHS) Act. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

- Your medical records;
 - The attending health care professional's recommendation;
 - Reports from appropriate health care professionals and other documents submitted by the Claims Administrator, you, or your treating Provider;
 - The terms of your Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
 - Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
 - Any applicable clinical review criteria developed and used by the Claims Administrator, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
 - The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.
- Written notice of the final external review decision must be provided within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the Claims Administrator and you or your authorized representative.
 - The notice of final external review decision will contain:
 - A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care Provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
 - The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
 - References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
 - A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
 - A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Claims Administrator or you or your authorized representative;
 - A statement that judicial review may be available to you or your authorized representative; and
 - Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.
 - After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the Claims Administrator, State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws, and you or your authorized representative.
- **Reversal of Plan's decision.** Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Claims Administrator must

immediately provide coverage or payment (including immediately authorizing or immediately paying Benefits) for the claim.

EXPEDITED EXTERNAL REVIEW

- **Request for expedited external review.** The Claims Administrator must allow you or your authorized representative to make a request for an expedited external review with the Claims Administrator at the time you receive:
 - An Adverse Benefit Determination, if the Adverse Benefit Determination involve a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
 - A Final Internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.
- **Preliminary review.** Immediately upon receipt of the request for expedited external review, the Claims Administrator must determine whether the request meets the reviewability requirements set forth in the “**Standard External Review**” section above. The Claims Administrator must immediately send you a notice of its eligibility determination that meets the requirements set forth in “**Standard External Review**” section above.
- **Referral to independent review organization.** Upon a determination that a request is eligible for external review following the preliminary review, the Claims Administrator will assign an IRO pursuant to the requirements set forth in the “**Standard External Review**” section above. The Claims Administrator must provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the Claims Administrator’s internal claims and appeals process.

- **Notice of final external review decision.** The Claims Administrator’s contract with the assigned IRO must require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in the “**Standard External Review**” section above, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the Claims Administrator and you or your authorized representative.

EXHAUSTION

For standard internal review, you have the right to request external review once the internal review process has been completed and you have received the Final Internal Adverse Benefit Determination. For expedited internal review, you may request external review simultaneously with the request for expedited internal review. The IRO will determine whether or not your request is appropriate for expedited external review or if the expedited internal review process must be completed before external review may be requested.

You will be deemed to have exhausted the internal review process and may request external review if the Claims Administrator waives the internal review process or the Claims Administrator has failed to comply with the internal claims and appeals process. In the event you have been deemed to exhaust the internal review process due to the failure by the Claims Administrator to comply with the internal claims and appeals process, you also have the right to pursue any available remedies under 502(a) of ERISA or under State law.

External review may not be requested for an Adverse Benefit Determination involving a claim for Benefits for a health care service that you have already received until the internal review process has been exhausted.

INTERPRETATION OF PLAN SPONSOR'S PLAN PROVISIONS

The Plan Administrator has given the Claims Administrator the initial authority to establish or construe the terms and conditions of the Health Benefit Plan and the discretion to interpret and determine Benefits in accordance with the Health Benefit Plan's provisions.

The Plan Administrator has all powers and authority necessary or appropriate to control and manage the operation and administration of the Health Benefit Plan.

All powers to be exercised by the Claims Administrator or the Plan Administrator shall be exercised in a non-discriminatory manner and shall be applied uniformly to assure similar treatment to persons in similar circumstances.

Employee Retirement Income Security Act of 1974 (ERISA)

As a participant in this Group Health Plan, you may be entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

If the Health Benefit Plan is part of an “employee welfare benefits plan” and “welfare plan” as those terms are defined in ERISA:

- The Plan Administrator will furnish summary plan descriptions, annual reports, and summary annual reports to you and other plan participants and to the government as required by ERISA and its regulations.
- The Claims Administrator will furnish the Plan Administrator with this Benefit Booklet as a description of Benefits available under this Health Benefit Plan. Upon written request by the Plan Administrator, the Claims Administrator will send any information which the Claims Administrator has that will aid the Plan Administrator in making its annual reports.
- Claims for Benefits must be made in writing on a timely basis in accordance with the provisions of this Health Benefit Plan. Claim filing and claim review health procedures are found in the “Claims Filing Procedures” and “Complaint/Appeal Procedures” sections of this Benefit Booklet.
- Blue Cross and Blue Shield of Oklahoma, as the Claims Administrator is not the ERISA “Plan Administrator” for Benefits or activities pertaining to the Health Benefit Plan.
- This Benefit Booklet is not a summary plan description.
- The Plan Administrator has given the Claims Administrator the authority and discretion to interpret the Health Benefit Plan provisions and to make eligibility and benefit determination. The Plan Administrator has full and complete authority and discretion to make decisions regarding the Health Benefit Plan’s provisions and determining questions of eligibility and Benefits. Any decisions made by the Plan Administrator shall be final and conclusive.

Check with your Plan Administrator to see if your Group Health Plan is governed by ERISA.

Definitions

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

ACTIVELY AT WORK

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

ALLOWABLE CHARGE

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

- **BlueChoice PPO Provider** — the Provider’s usual charge, not to exceed the amount the Provider has agreed to accept as payment for Covered Services in accordance with a BlueChoice PPO Provider Agreement.
- **Out-of-Network (Non-Contracting) Provider** — the lesser of: (a) the Provider’s billed charge; or (b) the Claims Administrator’s Non-contracting Allowable Charge as set forth in the *“Important Information”* section.

NOTE: For Covered Services received outside the state of Oklahoma, the “Allowable Charge” will be determined by the Blue Cross and Blue Shield Plan (Host Plan) servicing the area. Payment will be based upon the Provider payment arrangements in effect between the Provider and the on-site Plan. For out-of-network services, the Allowable Charge will be based upon the amount the Host Plan uses for their own local members.

AMBULATORY SURGICAL FACILITY

A Provider with an organized staff of Physicians which:

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

BENEFIT PERIOD

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

BENEFITS

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

BLUECARD PPO PROVIDER

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

BLUECHOICE PPO PROVIDER

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

CALENDAR YEAR

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

CERTIFICATE OF COVERAGE

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

COBRA CONTINUATION COVERAGE

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

COINSURANCE

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

COMMUNITY HOME HEALTH CARE AGENCY

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

COPAYMENT

A fixed dollar amount required to be paid by or on behalf of a Covered Person in connection with the delivery of Covered Services in a BlueChoice PPO or BlueCard PPO Physician's office.

COVERED PERSON

The Employee and each of his or her Dependents covered under this Plan.

COVERED SERVICE

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

CREDITABLE COVERAGE

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

CUSTODIAL CARE

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

DEDUCTIBLE

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

DEPENDENT

A Covered Person other than the Employee as shown in the *Eligibility, Enrollment, Changes and Termination* section.

DIAGNOSTIC SERVICE

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

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

DURABLE MEDICAL EQUIPMENT

Equipment which meets the following criteria:

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

EFFECTIVE DATE

The date when your coverage begins.

ELIGIBLE PERSON

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

EMERGENCY CARE

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

- serious jeopardy to the Covered Person’s health;
- serious impairment to bodily function; or
- serious dysfunction of any bodily organ or part.

EMPLOYEE

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

EMPLOYEE AND CHILDREN COVERAGE

Coverage under the Plan for the Employee and his or her Dependent child(ren).

EMPLOYEE ONLY COVERAGE (OR SINGLE COVERAGE)

Coverage under the Plan for the Employee only.

EMPLOYEE, SPOUSE AND CHILDREN COVERAGE (OR FAMILY COVERAGE)

Coverage under the Plan for the Employee, his or her spouse and Dependent child(ren).

EMPLOYEE AND SPOUSE ONLY COVERAGE

Coverage under the Plan for the Employee and his or her spouse only.

PLAN SPONSOR

Oklahoma Conference of The United Methodist Church

ENROLL

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

ENROLLMENT DATE

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

EXPERIMENTAL/INVESTIGATIONAL

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

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

FAMILY COVERAGE

Coverage under the Plan for the Employee and one or more of the Employee's Dependents.

GROUP HEALTH PLAN

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

HOSPICE

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

HOSPITAL

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

- Is licensed;
- Mainly provides Inpatient diagnostic and therapeutic services under the supervision of Physicians;
- Has organized departments of medicine and major Surgery;
- Provides 24-hour nursing service; and
- Is not, other than incidentally, a:
 - Skilled Nursing Facility;
 - Nursing home;
 - Custodial Care home;

- Health resort;
- Spa or sanitarium;
- Place for rest;
- Place for the aged;
- Place for the treatment of Mental Illness;
- Place for the treatment of alcoholism or drug abuse;
- Place for the provision of Hospice care;
- Place for the provision of rehabilitation care; or
- Place for the treatment of pulmonary tuberculosis.

HOSPITAL ADMISSION

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

IDENTIFICATION CARD

The card issued to the Employee by the Claims Administrator, bearing the Employee’s name, identification number, and Group number.

INCURRED

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

INITIAL ENROLLMENT PERIOD

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

INPATIENT

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

LATE ENROLLEE

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

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

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

- a court has ordered coverage be provided for a spouse or minor or Dependent child under the Eligible Person’s coverage and the request for enrollment is made within 31 days after issuance of the court order.

LICENSED PRACTICAL OR VOCATIONAL NURSE (LPN OR LVN)

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

LOW-DOSE MAMMOGRAPHY

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

MATERNITY SERVICES

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

MEDICAL CARE

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

MEDICALLY NECESSARY (OR MEDICAL NECESSITY)

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

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

MEDICARE

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

MENTAL ILLNESS

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

OPEN ENROLLMENT PERIOD

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

ORTHOGNATHIC SURGERY

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

OUT-OF-NETWORK PROVIDER

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

OUT-OF-POCKET LIMIT

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

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

OUTPATIENT

A Covered Person who receives services or supplies while not an Inpatient.

PHYSICIAN

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

PLACEMENT FOR ADOPTION (OR PLACED FOR ADOPTION)

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

PREAUTHORIZATION

Authorization from the Claims Administrator before the services are rendered that, based upon the information presented by the Covered Person or his/her Provider at the time Preauthorization is requested, the proposed treatment meets the Claims Administrator's guidelines for Medical Necessity.

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

PREEXISTING CONDITION

A condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the three-month period ending on the Enrollment Date. In order to be taken into account, the medical advice, diagnosis, care, or treatment must have been recommended by or received from an individual licensed or similarly authorized to provide such services under state law and operating within the scope of practice authorized by the state law. A Preexisting Condition shall not apply to Covered Persons under age 19.

PREEXISTING CONDITION EXCLUSION

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

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.

PROPERLY FILED CLAIM

A formal statement or claim regarding a loss which provides sufficient, substantiating information to allow the Claims Administrator to determine the Plan's 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 Claims Administrator.

PROVIDER

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

PSYCHIATRIC HOSPITAL

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

QUALIFYING EVENT

Any one of the following events which, but for the COBRA Continuation Coverage provisions of the Plan, would result in the loss of a Covered Person's coverage:

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

REGISTERED NURSE (RN)

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

RESIDENTIAL TREATMENT CENTER

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

ROUTINE NURSERY CARE

Ordinary Hospital nursery care of the newborn Covered Person.

SIGNIFICANT BREAK IN COVERAGE

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

SKILLED NURSING FACILITY

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

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

SPECIAL ENROLLMENT PERIOD

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

SURGERY

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

THERAPY SERVICE

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

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

- **Occupational Therapy** — treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role.
- **Speech Therapy** — treatment for the correction of a speech impairment resulting from disease, Surgery, injury, congenital and developmental anomalies, or previous therapeutic processes.

TOTAL DISABILITY (OR TOTALLY DISABLED)

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

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

The Claims Administrator 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 Covered Person's expense. The Plan will make the final determination as to whether the Covered Person is Totally Disabled.

URGENT CARE

Treatment for an unexpected illness or injury that is not an emergency, but which is severe or painful enough to require treatment within 24 hours. Examples include, but are not necessarily limited to: lacerations, high fever, severe vomiting and diarrhea, pulled muscles, or other similar illnesses or injuries.

WAITING PERIOD

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

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