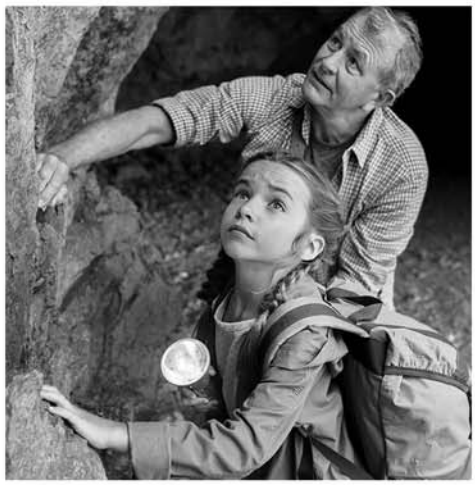
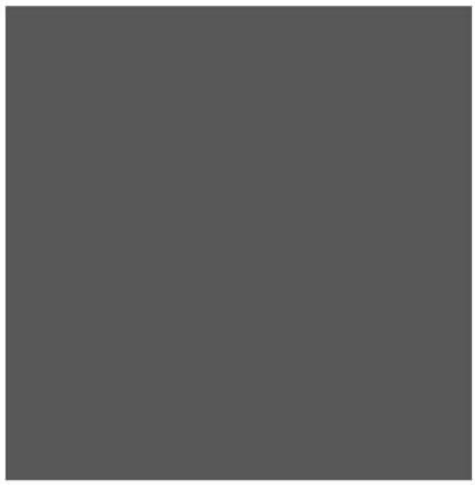
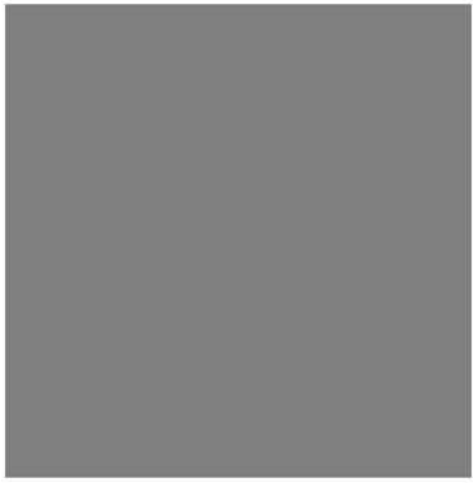
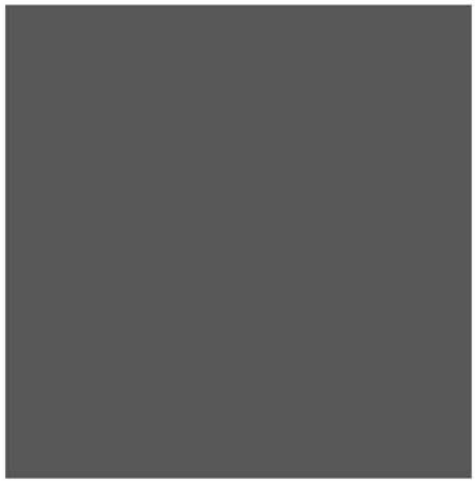
Administered by:

BlueCross BlueShield of Oklahoma






Your Health Care Benefits Program

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

For Employees of
Helmerich & Payne Management, LLC – $1,000 Deductible Plan
Blue Choice PPO℠
January 1, 2023

70260.0516

BENEFIT BOOKLET
NO SURPRISES ACT AMENDMENT

Amendment Effective Date: This Amendment is effective on the Employer's Contract Anniversary Date or for the Plan Year of your Employer's Group Health Plan occurring on or after January 1, 2022.

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

The Benefit Booklet is hereby amended as indicated below:

I. Continuity of Care

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

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

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

Continuity coverage described in this provision shall continue until the treatment is complete but will not extend for more than 90 days beyond the date The Plan notifies you of the Provider's termination, or any longer period provided by state law. If you are in the second or third trimester of pregnancy when the Provider's termination takes effect, continuity of coverage may be

extended through delivery of the child, immediate postpartum care, and the follow-up check-up within the first six (6) weeks of delivery. You have the right to appeal any decision made for a request for Benefits under this provision, as explained in the Benefit Booklet.

II. Federal No Surprises Act

1. Definitions

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

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

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

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

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

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

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

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

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

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

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

2. Federal No Surprises Act Surprise Billing Protections

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

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

b. Claim Payments

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

c. Cost-Sharing

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

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

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

3. Prohibition of Balance Billing

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

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

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

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

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

Blue Choice PPO℠
Blue Choice PPO℠ Network
Schedule of Benefits for Comprehensive Health Care Services

This schedule shows the Deductibles, Copayments and/or Coinsurance amounts that apply to Covered Services described in the ***Comprehensive Health Care Services*** section of your benefit booklet. **All Inpatient services and many Outpatient services require Prior Authorization approval from the Claims Administrator, as set forth in this benefit booklet. Please note that services must be Medically Necessary, as determined by the Plan, in order to be covered.**

BENEFIT PERIOD	Calendar Year
NETWORK PROVIDERS	To receive maximum Benefits under the Plan, you must receive services from Blue Choice Providers in Oklahoma or BlueCard Providers outside the state of Oklahoma. Refer to www.bcbsok.com or call a Customer Service Representative at the number shown on your Identification Card to find a Network Provider near you.

OFFICE VISIT COPAYMENT	The following Copayments will apply: • $30 for each Network Provider's office visit or Retail Health Clinic visit. • $30 for each Network Provider's office visit for Psychiatric Care Services. • $50 for each visit to a Network Specialist's office. • $50 for each visit to a Network Outpatient Therapy Services. • $75 for each visit to a Network Urgent Care facility. Cost shares for Covered Services provided through Virtual Visits will be the same as if provided in-person, except where otherwise noted. NOTE: For Covered Maternity Services, Copayment applies to initial prenatal visit only (per pregnancy). The Copayment applies to charges which are billed as part of the office visit, except for: • Preventive Care Services received from a Network Provider; • Annual mammography screening; • Covered childhood immunizations (for Covered Persons under age 19); • Surgical services; • Laboratory and x-ray services; • Magnetic resonance imaging (MRI), computed tomography (CT), positron emission tomography (PET), myocardial perfusion studies (MPS) and other similar imaging tests; • Chemotherapy; • Allergy testing and allergy injections; • Durable Medical Equipment. **Copayments do not apply to services received from Out-of-Network Providers.** **Allowable charges *are not* subject to the Benefit Period Deductible or Coinsurance.**

DEDUCTIBLES	
Emergency Room Deductible	$350 for each visit to a Hospital emergency room. This Deductible is waived if the Covered Person is admitted to the Hospital through the emergency room visit.
Non-Emergent Use of the Emergency Room Deductible	$350 for each visit to a Hospital emergency room. This Deductible is waived if the Covered Person is admitted to the Hospital through the emergency room visit. **In addition to the Emergency Room Deductible, the remaining Allowable Charges *are* subject to the Benefit Period Deductible and Coinsurance.**

Benefit Period Deductible	• **Network Provider Services** – $1,000 per Benefit Period per Covered Person, or $3,000 for all covered family members combined. • **Out-of-Network Provider Services** – $2,000 per Benefit Period per Covered Person, or $6,000 for all covered family members combined. Deductible amounts for Network Provider Services and Out-of-Network Provider Services cross-apply. The Benefit Period Deductible is in addition to the Emergency Room Deductible described above. The Benefit Period Deductible applies to all Covered Services, except: • Network Provider Services that are subject to the office visit Copayment. • Routine Nursery Care. • Preventive Care Services received from a Network Provider. • Preventive Care Services received from an Out-of-Network Provider are subject to Deductible, except for: — Annual mammography screening; — Covered Childhood Immunizations (for Covered Persons under age 19); — Any other state or federally mandated Benefits which stipulate a Deductible may not be required.

OUT-OF-POCKET LIMIT	• **Network Provider Services** – $3,000 per Covered Person, or $9,000 for all covered family members combined. When this limit has been paid (including any Copayment and/or Deductible amounts) for Covered Services provided by Network Providers during a Benefit Period, the amount of the Allowable Charges covered by the Plan for such Covered Person will increase to 100% during the remainder of the Benefit Period for Covered Services received from Network Providers. • **Out-of-Network Provider Services** – $6,000 per Covered Person, or $18,000 for all covered family members combined. When this limit has been paid (including any Copayment and/or Deductible amounts) for Covered Services provided by Out-of-Network Providers during a Benefit Period, the amount of the Allowable Charges covered by the Plan for such Covered Person will increase to 100% during the remainder of the Benefit Period for Out-of-Network Provider services. Out-of-Pocket Limits for Network Provider Services and Out-of-Network Provider Services cross-apply. This Out-of-Pocket Limit does not include any of the following: • Charges in excess of the Allowable Charge; • Services, supplies or charges limited or excluded by the Plan; • Expenses not covered because a Benefit maximum has been reached; • Any penalty incurred due to your failure to follow the Plan's requirements for Prior Authorization, as set forth elsewhere in this benefit booklet.
BENEFIT PERCENTAGE AMOUNT	The following chart shows the percentage of Allowable Charges covered by the Plan through payments and/or contractual arrangements with Providers. These percentages apply only after your Deductible and/or Copayment amounts have been satisfied. **NOTE: Any services classified as "Preventive Care Services" are paid at 100% of the Allowable Charge and are not subject to Deductibles, Copayments and/or Coinsurance, provided such services are received from Network Providers.**

COVERED SERVICES (Subject to the *Comprehensive Health Care Services* section)		
	BENEFIT PERCENTAGE OF ALLOWABLE CHARGES COVERED BY THE PLAN	
	Network Provider Services	**Out-of-Network Provider Services**
PREVENTIVE CARE SERVICES		
Annual Mammography Screening	100%	70%
Covered Childhood Immunizations	100%	70%
All Other Covered Preventive Care Services	100%	70%
EMERGENCY CARE SERVICES	90%	90%[1]
THE FOLLOWING BENEFIT PERCENTAGES APPLY TO SERVICES THAT ARE NOT CLASSIFIED AS PREVENTIVE CARE SERVICES OR EMERGENCY CARE SERVICES, AS DETERMINED BY THE PLAN		
HOSPITAL SERVICES[2]	90%	70%
SURGICAL/MEDICAL SERVICES		
Physician's Office Visit/Retail Health Clinic Visit/Urgent Care	100%[3]	70%
All Other Covered Surgical/Medical Services	90%	70%
OUTPATIENT DIAGNOSTIC SERVICES	90%	70%
OUTPATIENT THERAPY SERVICES[2] Maximum of 50 Outpatient visits for Physical Therapy, Occupational Therapy and Speech Therapy (combined) per Benefit Period	100%[3]	70%
MATERNITY SERVICES[4]	90%	70%
MASTECTOMY AND RECONSTRUCTIVE SURGICAL SERVICES	90%	70%
HUMAN ORGAN, TISSUE AND BONE MARROW TRANSPLANT SERVICES[2]	90%	70%
AMBULATORY SURGICAL FACILITY SERVICES	90%	70%

[1] *Treatment in an emergency room for other than Emergency Care, the percentage amount is reduced to 70% of Allowable Charges for services received from Out-of-Network Providers after satisfaction of the Deductible.*

[2] *All Inpatient Services and certain Outpatient services are subject to Prior Authorization approval from the Claims Administrator. See the* ***Important Information*** *section for details regarding "Prior Authorization" requirements.*

[3] *Applicable only to Covered Services which are subject to the office visit Copayment. For services which are not subject to the office visit Copayment, this percentage amount is reduced to 90% of Allowable Charges after satisfaction of the Deductible.*

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

	BENEFIT PERCENTAGE OF ALLOWABLE CHARGES COVERED BY THE PLAN	
	Network Provider Services	**Out-of-Network Provider Services**
SERVICES RELATED TO TREATMENT OF AUTISM SPECTRUM DISORDER Physical Therapy, Occupational Therapy and Speech Therapy visits are unlimited for Covered Persons	90%	60%
PSYCHIATRIC CARE SERVICES[1]		
Physician's Office Visit/Retail Health Clinic Visit	100%[2]	70%
All Other Covered Psychiatric Care Services	90%	70%
AMBULANCE SERVICES	90%	70%
PRIVATE DUTY NURSING SERVICES[1] 85 visit maximum per Benefit Period	90%	70%
REHABILITATION CARE[1] 90-day maximum per Benefit Period	90%	70%
CARDIAC REHABILITATION CARE[3]	90%	70%
SKILLED NURSING FACILITY SERVICES[1] 60-day maximum per Benefit Period	90%	70%
HOME HEALTH CARE SERVICES[1] 100 visit maximum per Benefit Period	90%	70%
HOSPICE SERVICES[1] Maximum of 5 days in a 30 day Period	90%	70%
DENTAL SERVICES FOR ACCIDENTAL INJURY	90%	70%
AUDIOLOGICAL SERVICES Limited to one hearing aid per ear every 48 months for Covered Persons up to age 18	90%	70%
DIABETES EQUIPMENT, SUPPLIES AND SELF-MANAGEMENT SERVICES	90%	70%
SERVICES RELATED TO CLINICAL TRIALS	90%	70%

[1] *All Inpatient Services and certain Outpatient services are subject to Prior Authorization approval from the Claims Administrator. See the* ***Important Information*** *section for details regarding "Prior Authorization" requirements.*

[2] *Applicable only to Covered Services which are subject to the office visit Copayment. For services which are not subject to the office visit Copayment, this percentage amount is reduced to 90% of Allowable Charges after satisfaction of the Deductible.*

[3] *Limited to 36 sessions within a 12-week period and the program must start within 90 days of the cardiac event.*

	BENEFIT PERCENTAGE OF ALLOWABLE CHARGES COVERED BY THE PLAN	
	Network Provider Services	**Out-of-Network Provider Services**
DURABLE MEDICAL EQUIPMENT	90%	70%
PROSTHETIC APPLIANCES	90%	70%
ORTHOTIC DEVICES Maximum of 15 per Benefit Period	90%	70%
WIGS OR OTHER SCALP PROSTHESES Maximum of two per Benefit Period	90%	70%
CHIROPRACTIC MEDICAL SERVICES	90%	70%
MUSCLE MANIPULATIONS Maximum of 25 visits per Benefit Period	90%	70%
ALL OTHER COVERED SERVICES	90%	70%

Table of Contents

Plan Summary

Helmerich & Payne Management, LLC (called the ***Employer***) has established and maintains a self-insured Plan of Comprehensive Health Care Benefits (called the ***Plan***) for its eligible Employees and other persons as designated in its personnel policy.

The Plan is operated under an Administrative Services Agreement between your Employer 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 the ***Claims Administrator***).

Under this Agreement, the Claims Administrator provides Benefits on behalf of your Employer in accordance with the terms of the Plan and performs certain other services on behalf of your Employer. Your Employer 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 or benefit booklets previously issued for the Employees under the Plan. It describes the Plan in effect as of January 1, 2023, 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 coverage. Together, these features allow you to receive quality health care in cost-effective settings, while helping you experience lower out-of-pocket expenses.

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

Your Participating Provider Network

Your coverage is a Preferred Provider Organization (PPO) plan that offers a wide choice of network doctors and Hospitals. 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 coverage will provide the highest level of Benefits if you use a Network Provider.

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

How Your Coverage Works

Your coverage is designed to give 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 Network Provider.

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

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

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

Cost Sharing Features of Your Coverage

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

Selecting a Provider

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

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

The BlueCard® Program

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

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

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

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

- The billed covered charges for your Covered Services; or
- The negotiated price that the Host Blue makes available to the Plan.

To help you understand how this calculation would work, please consider the following example:

a. Suppose you receive Covered Services for an illness while you are on vacation outside of Oklahoma**.** You show your identification card to the Provider to let him or her know that you are covered by the Plan.

b. The Provider has negotiated with the Host Blue a price of $80, even though the Provider's standard charge for this service is $100. In this example, the Provider bills the Host Blue $100.

c. The Host Blue, in turn, forwards the claim to the Plan and indicates that the negotiated price for the Covered Service is $80. The Plan would then base the amount you must pay for the service – the amount applied to your Deductible, if any, and your Coinsurance percentage – on the $80 negotiated price, not the $100 billed charge.

d. So, for example, if your Coinsurance is 20%, you would pay $16 (20% of $80), not $20 (20% of $100). You are not responsible for amounts over the negotiated price for a Covered Service.

- **Finding a Physician or Hospital**

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

- **Available Care Coast to Coast**

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

- **Remember to Always Carry the BlueCard**

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

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

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

How The BlueCard Program Works

- You're outside the state of Oklahoma and need health care.
- Call 1-800-810-BLUE (2583) for information on the nearest Participating Physicians and Hospitals, or visit the BlueCard website at http://www.bluecares.com.
- Your Network Provider is required to obtain Prior Authorization for Inpatient Hospital admissions. You are responsible for satisfying all other Prior Authorization requirements, if applicable, from Blue Cross and Blue Shield of Oklahoma.
- Visit the participating Physician or Hospital and present your Identification Card.
- The participating Physician or Hospital verifies your membership and coverage information.
- After you receive medical attention, your claim is electronically routed to Blue Cross and Blue Shield of Oklahoma, which processes it and sends you a detailed Explanation of Benefits. You are only responsible for meeting your Deductible, Copayment and/or Coinsurance payments, if any.
- All participating Physicians and Hospitals are paid directly.

Utilization Management

Utilization management may be referred to as Medical Necessity reviews, utilization review (UR) or medical management reviews. A Medical Necessity review for a procedure/service, Inpatient admission, and length of stay is based on BCBSOK Medical Policy and/or level of care review criteria. Medical Necessity reviews may occur prior to services rendered, during the course of care, or after care has been completed for a Post-Service Medical Necessity Review. Some services may require a Prior Authorization before the start of services, while other services will be subject to a Post-Service Medical Necessity Review. If requested, services normally subject to a Post-Service Medical Necessity review may be reviewed for Medical Necessity prior to the service through a Recommended Clinical Review as defined below.

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

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

PRIOR AUTHORIZATION

Prior Authorization is a requirement that you must obtain authorization from Blue Cross and Blue Shield before you receive a certain type of Covered Services designated by Blue Cross and Blue Shield in order to be eligible for maximum benefits. However, for Inpatient Hospital facility services, your Participating Provider is required to obtain Prior Authorization. If Prior Authorization is not obtained, the Participating Provider will be sanctioned based on Blue Cross Blue Shield's contractual agreement with the Provider, and the member will be held harmless for the Provider sanction. For additional information about Prior Authorization for services outside of our service area, see the section entitled, "THE BLUECARD® PROGRAM."

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

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

If you utilize a Network Provider for Inpatient Hospital Covered Services, that Provider is required to obtain Prior Authorization for the services. However, it is ***the Covered Person's*** responsibility to assure that all other services receive Prior Authorization before receiving care. You or your Provider should obtain Prior Authorization by calling the Prior Authorization number shown on your Identification Card ***before*** receiving treatment.

- **Prior Authorization Process for Inpatient Services**

  For an Inpatient facility stay, *your Provider must request Prior Authorization from the Claims Administrator as soon as possible, but no later than one business day* ***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 different 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.

  Your Network Provider is required to obtain Prior Authorization for any Inpatient admissions. If Prior Authorization is not obtained, the Network Provider will be sanctioned based on BCBSOK's contractual agreement with the Provider, and you will be held harmless for the Provider sanction. For Inpatient services received outside of our service area, see the section entitled, "The BlueCard® Program" in ***General Provisions.***

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

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

  All **Inpatient** services (including partial hospitalization programs) related to treatment of Mental Illness, drug addiction, substance abuse or alcoholism must be approved through Prior Authorization by the Claims Administrator.

- **Prior Authorization Requests Involving Emergency Care**

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

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

  You must request Prior Authorization from the Plan at least two business days prior to receiving certain **Outpatient** services. To determine if a specific service or category requires Prior Authorization, visit our website at www.bcbsok.com/find-care/where-you-go-matters/utilization-management.com for the required Prior Authorization list, which is updated when new services are added or when services are removed. Please refer to the section entitled Utilization Management for information regarding Prior Authorization Requirements:

  - Hospice Services;
  - Home Health Care Services;
  - Private Duty Nursing Services;
  - Home Infusion Therapy;
  - Outpatient Infusion Drugs;
  - Applied Behavior Analysis; and
  - Any of the following Psychiatric Care Services:
    - Psychological testing;
    - Neuropsychological testing;
    - Electroconvulsive therapy;
    - Intensive Outpatient Treatment;
    - Repetitive Transcranial Magnetic Stimulation.

  If you fail to request Prior Authorization, your Benefits under this Group Health Plan may be reduced, as described below under "*Failure to obtain Prior Authorization*".

- **Failure to obtain Prior Authorization**

  If the Covered Person does not call for Prior Authorization for the services listed above, except Molecular genetic testing, Applied Behavior Analysis and Psychiatric Care Services, these services will be subject to a 25% up to $500 reduction in Benefits if, upon receipt of a claim, it is determined by the Claims Administrator that services were Medically Necessary. If it is determined that the services were not Medically Necessary or were Experimental, Investigational and/or Unproven, it may be the Covered Person's responsibility to pay the full cost of the services received.

  If the Covered Person fails to obtain Prior Authorization for Molecular genetic testing, Applied Behavior Analysis and Psychiatric Care Services:

  - 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 and/or Unproven, Benefits will be reduced or denied.

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

- **Response to Prior Authorization Requests**

  The Claims Administrator will provide a written response to your Prior Authorization 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 its control.

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

If an extension of time is necessary due to the need for additional information, the Claims Administrator will notify you of the specific information needed, and you will have 45 days from receipt of the notice to provide the additional information. The Claims Administrator will provide a written response to your request for *Prior Authorization* within 15 days following receipt of the additional information.

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

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

  A "*Prior Authorization Request Involving Urgent Care*" is any request for Medical Care or treatment with respect to which the 15-day review period set forth above:

  - could seriously jeopardize the life or health of the 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 Prior Authorization request.

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

  The Claims Administrator's response to your "*Prior Authorization Request Involving Urgent Care*", including an adverse determination, if applicable, may be issued orally. A written notice will also be provided within three days following the oral notification.

Length of Stay/Service review

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

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

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

A length of stay/service review, also known as a concurrent Medical Necessity review, is when you, your Provider, or other authorized representative may submit a request to the Plan for continued services. If you, your Provider or authorized representative requests to extend care beyond the approved time limit and it is a request involving urgent care or an ongoing course of treatment, the Plan will make a determination on the request/appeal as soon as possible but no later than 72 hours after it receives the initial request, or within 48 hours after it receives the missing information (if the initial request is incomplete).

Recommended Clinical Review

Some services that do not require Prior Authorization may be subject to review for evidence of medical necessity for coverage determinations that may occur prior to services rendered, during the course of care or after care has been completed for a Post-Service Medical Necessity Review.

A Recommended Clinical Review is a Medical Necessity review for a Covered Service that occurs before services are completed and helps limit the situations are where you have to pay for a non-approved service. BCBSOK will review the request to determine if it meets approved BCBSOK medical policy and/or level of care review criteria for medical and behavioral health services. Once a decision has been made on the services reviewed as part of the Recommended Clinical Review process, they will not be reviewed for Medical Necessity again on a retrospective basis. Submitted services (subject to Medical Necessity review) not included as part of Recommended Clinical Review may be reviewed retrospectively.

To determine if a Recommended Clinical Review is available for a specific service, visit our website at www.bcbsok.com/findcare/where-you-go-matters/utilization-management.com for the required Prior Authorization and Recommended Clinical Review list, which is updated when new services are added or when services are removed. You can also call Customer Service at the toll-free telephone number on the back of your Identification Card. You or your Provider may request a Recommended Clinical Review.

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

Below are some examples (not an exhaustive list) of some common services for which a Recommended Clinical Review is recommended:

- Certain higher cost durable medical equipment;
- Surgeries that might be considered cosmetic; and
- Services and supplies that may be Experimental/Investigational under certain circumstances

General Provisions Applicable to all Recommended Clinical Reviews

- **No Guarantee of Payment**

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

- **Request for Additional Information**

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

Post-Service Medical Necessity review

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

General Provisions Applicable to All Post-Service Medical Necessity Reviews

- **No Guarantee of Payment**

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

- **Request for Additional Information**

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

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 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 as Emergency Care. Emergency Care is defined as 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;
- 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 Network Providers in Oklahoma and BlueCard Providers whenever you are out of state. Using a Network Provider offers you the following advantages:

- Network Providers have agreed to hold the line on health care costs by providing special prices for 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 are not eligible under your coverage, then subtract any Deductible, Copayment 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 Network Provider or a BlueCard Provider outside the state of Oklahoma.

The Plan uses the following method for 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:**

  1. the Provider's billed charges; or

  2. 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 60% of the base Medicare reimbursement rate. However, in no event will the reimbursement exceed 90% of the lowest amount the Plan would have paid a Network Provider for the same services.

  For services for which a Medicare reimbursement rate is not available, the Allowable Charge for Non-Contracting Providers will represent an average contract rate for Network Providers adjusted by a predetermined factor established by the Claims Administrator and updated on a periodic basis. Such factor shall not be less than 90% of the average contract rate. 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 Deductible, Copayment and/or Coinsurance amounts. 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.

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

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

- Charges for any services which are not covered under your Plan.
- Any Deductible, Copayment and/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, or changes in your health care program, or the special needs of your Plan, provisions called "special notices" may be added to the Plan.

Be sure to check for "special notices". It changes provisions or Benefits in your 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 Plan 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 "*Request for Prior Authorization Involving Inpatient Service for Urgent Care*" (see "*Prior Authorization*" provisions), a health care professional with knowledge of your medical condition will be permitted to act as your authorized representative.

Questions

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 book. If you need more help, please call a Customer Service Representative at the toll-free number shown on your Identification Card.

Or you can write to:

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

When you call or write, be sure to give your Blue Cross and Blue Shield of Oklahoma 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

Please Consult your Plan Administrator for Eligiblity, Enrollment, Changes & Termination requirements.

Comprehensive Health Care Services

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

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

Preventive Care Services

NOTE: Preventive Care Services received from Network Providers and BlueCard Providers are not subject to Deductible, Copayment and/or Coinsurance and/or dollar maximums. Preventive Care Services received from Out-of-Network Providers may be subject to Deductible, Copayment and/or Coinsurance.

1. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF");

2. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved;

3. Evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") for infants, children, and adolescents; and

4. With respect to women, such additional preventive care and screenings, not described above, as provided for in comprehensive guidelines supported by the HRSA. Such services will include the following:

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

   - Breast-feeding Support, Services and Supplies – Benefits will be provided for breast-feeding counseling and support services rendered by a Provider for pregnant and postpartum women. In addition, benefits are provided for the rental of hospital grade breast pumps (not to exceed the total cost) or purchase of manual or electric grade breast pumps; including breast pump supplies and breast milk storage supplies, with a written prescription from a Provider, and are not subject to coinsurance, deductible, copayment, or benefit maximums when received from a Network Provider. Benefits for electric grade breast pumps are limited to one per Benefit Period.

   - Contraceptive Services – Benefits will be provided for the following contraceptive services when prescribed by a licensed Provider for women with reproductive capacity:

     — contraceptive counseling;

     — FDA-approved prescription devices and medications;

     — over-the-counter contraceptives; and

     — sterilization procedures (including, but not limited to, tubal ligation), but not including hysterectomy.

     Coverage includes contraceptives in the following categories:

     — progestin-only contraceptives;

     — combination contraceptives;

- emergency contraceptives;
- extended-cycle/continuous oral contraceptives;
- cervical caps;
- diaphragms;
- implantable contraceptives;
- intra-uterine devices;
- injectables;
- transdermal contraceptives; and
- vaginal contraceptive devices.

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

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

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

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

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

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

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

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

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

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

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

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

Emergency Care Services

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

- serious jeopardy to the Covered Person's health (or, with respect to a pregnant woman, the health of the woman or her unborn child);
- serious impairment to bodily function;
- serious dysfunction of any bodily organ or part; or
- with respect to a pregnant woman who is having contractions:
  - — there is inadequate time to effect a safe transfer to another hospital before delivery, or
  - — transfer may pose a threat to the health or safety of the woman or the unborn child.

Coverage for Emergency Care shall be provided in accordance with the terms and conditions of the appropriate Benefit section of this benefit booklet (for example: *"Hospital Services"* and *"Surgical/Medical Services"*). If you disagree with the Claim Administrator's determination in processing your benefits as non-emergency care instead of Emergency Care, you may call the Claim Administrator at the number on the back of your ID card. Please review the *Review of Claim Determinations* provision of this benefit booklet for specific information on your right to seek and obtain a full and fair review of your claim.

Services provided in an emergency room that are not Emergency Care may be excluded from emergency coverage, although these services may be covered under another benefit, if applicable. Non-emergency services provided in an emergency room for treatment of Mental Illness or substance abuse disorder will be paid the same as Emergency Care 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 *"Prior Authorization"* requirements of the Plan (see *Important Information* section). If you fail to comply with these requirements, Benefits for Covered Services rendered during your Inpatient confinement will be reduced by 25% up to $500, provided the Claims Administrator determines that Benefits are available upon receipt of a claim.

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

  Benefits include 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 available for only the primary procedure. **Separate Benefits will not be available for any incidental procedures performed at the same time.**

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

    ○ the primary procedure; plus

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

  — Sterilization, regardless of Medical Necessity.

- **Assistant Surgeon**

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

**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.*

— 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.

— **Diagnostic Examination for Breast Cancer**

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

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

This examination may include, but is not limited to, a Diagnostic Mammogram, Breast Magnetic Resonance Imaging, or a Breast Ultrasound. Benefits for a Diagnostic Examination for Breast Cancer will be provided at no cost share.

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

Diagnostic Mammogram

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

Breast Magnetic Resonance Imaging

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

Breast Ultrasound

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

— Audiological Services

Audiological services and hearing aids, 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.

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

— Chiropractic Medical Services

Services for chiropractic care are limited to the office visit and X-rays when provided by a Chiropractor.

— Muscle Manipulations

Services for muscle manipulations are limited to the number of visits specified in *Schedule of Benefits for Comprehensive Health Care Services*.

— Cardiac Rehabilitation

Services for Cardiac Rehabilitation are limited to the number of days specified in *Schedule of Benefits for Comprehensive Health Care Services*.

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

  Radiation Therapy Services are subject to the "*Prior Authorization*" requirements of this benefit booklet (see *Important Information* section). If you fail to comply with these requirements, Benefits for Covered Services will be reduced by 25% up to $500, provided the Claims Administrator determines that Benefits are available upon receipt of a claim.

- Chemotherapy
- Respiratory Therapy
- Dialysis Treatment
- Home Infusion Therapy
- Physical Therapy**,** Occupational Therapy and Speech Therapy

  Benefits for Outpatient Physical Therapy, Outpatient Occupational Therapy and Outpatient Speech Therapy (including visits to the Covered Person's home) are limited to the number of visits specified in the *Schedule of Benefits for Comprehensive Health Care Services*. This visit limit is not applicable to Therapy Services for treatment of Autism Spectrum Disorder.

Maternity Services

- *"Hospital Services"* and *"Surgical/Medical Services"* from a Provider (including the services of midwives) for:
  - Normal Pregnancy

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

    Physical effects directly caused by pregnancy but which are not considered from a medical viewpoint to be the effect of normal pregnancy, including conditions related to ectopic pregnancy or those that require cesarean section.
  - Interruptions of Pregnancy
    - Miscarriage.
    - Abortion, when the mother's life is endangered.
    - Therapeutic Abortion, when the mother's life is endangered.
- Covered Maternity Services include the following:
  - A minimum of 48 hours of Inpatient care at a Hospital, or a birthing center licensed as a Hospital, following a vaginal delivery for the mother and newborn infant who are covered under 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 post-discharge; and
    - the availability of post-discharge follow-up to verify the condition of the newborn infant in the first 48 hours after delivery; 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, including complications of pregnancy.

Mastectomy and Reconstructive Surgical Services

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

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

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

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

Human Organ, Tissue and Bone Marrow Transplant Services

All transplants are subject to Prior Authorization 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.

Prior Authorization must be obtained at the time the Covered Person is referred for a transplant consultation and/or evaluation. It is the Provider's responsibility to make sure Prior Authorization is obtained for Inpatient Hospital admissions. The Plan has the sole and final authority for approving or declining requests for Prior Authorization.

- **Definitions**

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

  — **Bone Marrow Transplant**

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

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

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

  — **High-Dose Chemotherapy**

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

  — **High-Dose Radiation Therapy**

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

  — **Prior Authorization**

  The process that determines in advance the Medical Necessity or Experimental, Investigational and/or Unproven nature of certain care and services under the Plan. Prior Authorization is subject to all conditions,

exclusions and limitations of the Plan. Prior Authorization 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 this 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 this benefit booklet, 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, Investigational and/or Unproven in nature.
- Expenses related to the purchase, evaluation, Procurement Services or transplant procedure if the organ or tissue or bone marrow or stem cells or progenitor cells are sold rather than donated to the 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 this benefit booklet.

— 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 applied to 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 Claims Administrator as Experimental, Investigational and/or Unproven (see ***Definitions*** and ***Exclusions***) are eligible for Benefits if the Bone Marrow Transplant meets all of the following criteria:

  — It is therapeutic (not diagnostic or supportive) treatment used to directly improve health outcomes for a condition that is life threatening and that has a poor prognosis with the most effective conventional

treatment. For purposes of this provision, a condition is considered life threatening if it has a substantial probability of causing premature death and all other conventional treatments have failed, or are not medically appropriate;

— The Bone Marrow Transplant is available to the 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 Spectrum Disorder

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

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

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

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

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

Psychiatric Care Services

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

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 (including partial hospitalization programs).

- Inpatient Medical Services

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

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

  — Individual Psychotherapy;

  — Group Psychotherapy;

  — Psychological Testing; and

  — Convulsive Therapy Treatment.

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

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

- Outpatient Psychiatric Care Services

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

- Drug Addiction, Substance Abuse and Alcoholism

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

- Substance Use disorder

  Substance use disorder benefits are covered as any other medical services.

  Changes for certified addition counselors are also covered medical expenses if a covered person's treatment is in connection with an accredited outpatient substance abuse treatment program.

Ambulance Services

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

Private Duty Nursing Services

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

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

Private Duty Nursing Services are subject to the *"Prior Authorization"* requirements of the Plan (see *Important Information* section). Failure to comply with these requirements will result in a 25% up to $500 reduction in Benefits for Private Duty Nursing if, upon receipt of a claim, Benefits are available under the Plan.

Rehabilitation Care

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

Benefits for Rehabilitation Care are limited to the number of days specified in the *Schedule of Benefits for Comprehensive Health Care Services.*

Rehabilitation Care is subject to the *"Prior Authorization"* requirements of the Plan (see *Important Information* section). Failure to comply with these requirements will result in a 25% up to $500 reduction in Benefits for Rehabilitation Care if, upon receipt of a claim, Benefits are available under the Plan.

Skilled Nursing Facility Services

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

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

Skilled Nursing Facility Services are subject to the *"Prior Authorization"* requirements of the Plan (see *Important Information* section). Failure to comply with these requirements will result in a 25% up to $500 reduction in Benefits for Skilled Nursing Facility Services if, upon receipt of a claim, Benefits are available under the Plan.

No Benefits are available:

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

Home Health Care Services

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

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

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

- Professional services of an RN, LPN or LVN;
- Medical social service consultations;
- Health aide services while you are receiving covered nursing or Therapy Services;
- Services of a licensed registered dietitian or licensed certified nutritionist, when authorized by the patient's supervising Physician and when Medically Necessary as part of diabetes self-management training.
- Services provided by a licensed or certified midwife or nurse midwife.

Home Health Care is subject to the *"Prior Authorization"* requirements of the Plan (see "*Important Information*" section). Failure to comply with these requirements will result in a 25% up to $500 reduction in Benefits for Home Health Care Services if, upon receipt of a claim, Benefits are available under the Plan.

The Plan does not pay Home Health Care Benefits for:

- Dietitian services, except as specified for diabetes self-management training;
- Homemaker services;
- Maintenance therapy;
- Speech Therapy;
- Durable Medical Equipment;
- Food or home-delivered meals;
- Infusion Therapy, **except when you have received Prior Authorization from the 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.

Benefits for Hospice Services also include:

- Bereavement counseling for the Covered Person's immediate family before, and within three months after, the Covered Person's death; and
- Respite care for up to five days in any 30 day period. "Respite Care" means care provided to a dying Covered Person when a family member or other care giver cannot be with the patient because of an emergency or due to the need for a break from the daily demands of caring for the terminally ill person.

Benefits for Hospice Services are limited to the number of days specified in the *Schedule of Benefits for Comprehensive Health Care Services.*

Hospice Services are subject to the *"Prior Authorization"* requirements of the Plan (Please refer to the section entitled Utilization Management for information regarding Prior Authorization requirements). Failure to comply with these requirements will result in a 25% up to $500 reduction in Benefits for Hospice Services, if, upon receipt of a claim, Benefits are available 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.

Diabetes Equipment, Supplies and Self-Management Services

- The following equipment, supplies and related services for the treatment of Type I, Type II and gestational diabetes when Medically Necessary and when recommended or prescribed by a Physician or other Provider:
  - — Blood glucose monitors;
  - — Blood glucose monitors to the legally blind;
  - — Test strips for glucose monitors;
  - — Visual reading and urine testing strips;
  - — Insulin;
  - — Injection aids;
  - — Cartridges for the legally blind;
  - — Syringes;
  - — Insulin pumps and appurtenances thereto;
  - — Insulin infusion devices;
  - — Oral agents for controlling blood sugar;
  - — Podiatric appliances for prevention of complications associated with diabetes; and

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

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

  — Visits Medically Necessary upon the diagnosis of diabetes;

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

  — Visits when reeducation or refresher training is Medically Necessary.

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

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

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

Services Related to Clinical Trials

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

- Any of the following federally funded or approved trials:

  — The Centers for Disease Control and Prevention of the United States Department of Health and Human Services;

  — The National Institutes of Health (NIH);

  — The Centers for Medicare and Medicaid Services;

  — The Agency for Healthcare Research and Quality;

  — A cooperative group or center of any of the previous entities;

  — The United States Food and Drug Administration;

  — The United States Department of Defense (DOD);

— The United States Department of Veterans Affairs (VA);

— A qualified non-governmental research entity identified in guidelines issued by the NIH for center support grants or the DOD, VA or Department of Energy if the study has been reviewed and approved through a peer review system; or

— An institutional review board of an institution in this state that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services.

- A clinical trial conducted under an FDA investigational new drug application.
- A drug trial that is exempt from the requirement of an FDA investigational new drug application.

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

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

- The investigational item, device or service, itself;
- Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Durable Medical Equipment

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

- It is used in the Covered Person's home, place of residence or dwelling;
- 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
- 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 determined to be Medically Necessary.

Orthotic Devices

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

Benefits will be provided for the following orthotic devices:

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

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

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

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

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 Radiation Therapy or Chemotherapy.

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

Exclusions

This section lists what is not covered. Your Employer wants to be sure that you do not expect Benefits that are not included in the Plan.

What Is Not Covered

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

- Any services, supplies or drugs provided to a Covered Person incurred outside the United States if the Covered Person traveled to the location for the purposes of receiving medical services, supplies or drugs.
- For cosmetic Surgery or complications resulting therefrom, including Surgery to improve or restore your appearance, unless:

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

  — for the improvement of the physiological functioning of a malformed body member resulting from a congenital defect.

  In no event will any care and services for breast reconstruction or implantation or removal of breast prostheses be a Covered Service unless such care and services are performed solely and directly as a result of mastectomy which is Medically Necessary.
- Received from a member of your immediate family.
- Received before the Covered Person's Effective Date.
- Received after the Covered Person's coverage stops.
- 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.
- For personal hygiene and convenience items regardless of whether or not recommended by a Physician or other Provider. Examples include: computers; air conditioners, air purifiers or filters; humidifiers; or physical fitness equipment, including exercise bicycles or treadmills; or modifications to your home or vehicle.
- For telephone consultations, email or other electronic consultations (except electronic consultations occurring with a Provider in connection with a "medical home" program that has been approved by the Plan), 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.
- For foot care only to improve comfort or appearance such as care for flat feet, subluxation, corns, bunions (except capsular and bone Surgery), calluses, toenails, and the like.
- For routine, screening or periodic physical examinations which are not included as *"Preventive Care Services",* as specified in the ***Comprehensive Health Care Services*** section of this benefit booklet.
- For reverse sterilization.
- For female contraceptive devices when not prescribed by a licensed Provider, including over-the-counter contraceptive products. Contraceptive medications or devices for male use are excluded.
- For or related to the planned delivery of a newborn child at home, or in any setting other than a Hospital, licensed birthing center or other facility licensed to provide such services.
- For Orthognathic Surgery, osteotomy or any other form of oral Surgery, dentistry or dental processes to the teeth and surrounding tissue (including complications resulting therefrom), except for:

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

  — for the improvement of the physiological functioning of a malformed body member resulting from a congenital defect;

— dental extractions performed in preparation for radiation treatment for neoplasms involving the jaw/mouth; or

— dental extractions of diseased teeth prior to a solid organ transplant.

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

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

  — four years of age or under, who, in the judgment of the practitioner treating the child, is not of sufficient emotional development to undergo a Medically Necessary dental procedure without the use of anesthesia.

- 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; or

  — vision examinations performed in connection with the diagnosis or treatment of disease or injury; or

  — services specified under "*Preventive Care Services*" in the ***Comprehensive Health Care Services*** section.

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

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

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

- For treatment of obesity, including morbid obesity, regardless of the patient's history or diagnosis, including, but not limited to the following: weight reduction or dietary control programs; bariatric surgery or other surgical procedures for weight reduction; 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 tobacco cessation programs (not including counseling or medications as specified under *"Preventive Care Services"*).

- For medication, drugs or hormones to stimulate growth.

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

- For conditions related to hyperkinetic syndromes, learning disabilities, mental disability or for Inpatient confinement for environmental change. This exclusion ***shall not*** apply to the services of a Physician or other Provider (except for neuropsychological testing) related to the diagnosis and treatment of attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD).

- For unspecified developmental disorders or autistic disease of childhood, except as specified in the ***Comprehensive Health Care Services*** section under *"Services Related to Treatment of Autism Spectrum Disorder"*.
- For hippotherapy, equine assisted learning or other therapeutic riding programs.
- For which the Provider of service customarily makes no direct charge to a Covered Person.
- Received from a Skilled Nursing Facility, Home Health Care Agency, Hospice or rehabilitation facility which is not a Plan-approved Provider.
- For treatment of temporomandibular joint dysfunction, including but not limited to diagnostic procedures, splints, orthodontic/orthopedic appliances, restorations necessary to increase vertical dimension or to restore or maintain functional or centric occlusion, alteration of teeth or jaws, Physical Therapy and medication and behavioral modification related to conditions of temporomandibular joint syndrome or any other conditions involving the jaw joint, adjacent muscles or nerves, regardless of cause or diagnosis.
- For or related to transplantation of donor organs, tissues or bone marrow, except as specified under *"Human Organ, Tissue and Bone Marrow Transplant Services"*.
- For Physician standby services.
- For Continuous Passive Motion (CPM) devices used in treatment of the shoulder or other joints, except for up to 21 days postoperatively for certain knee procedures determined to be Medically Necessary per our medical policy.
- For ductal lavage of the mammary ducts.
- For human donor milk.
- For extracorporeal shock wave treatment, also known as orthotripsy, using either a high-or low-dose protocol, for treatment of plantar fasciitis and all other musculoskeletal conditions.
- For orthoptic training.
- For thermal capsulorrhaphy as a treatment of joint instability, including but not limited to instability of shoulders, knees and elbows.
- For elective abortion, unless the life of the mother is endangered.
- For transcutaneous electrical nerve stimulator (TENS).
- For Inpatient drug and alcohol treatment that is not rendered in a Hospital, Psychiatric Hospital, Residential Treatment Center or other Plan-approved Provider.
- For massage therapy, including but not limited to effleurage, petrissage and/or tapotement.
- For transportation services, except as described under "*Ambulance Services*" in the ***Comprehensive Health Care Services*** section of this benefit booklet.
- For any self-injectable and other self-administered drugs purchased from a Physician and administered in his/her office.
- For any related services to a non-covered service. Related services are:

    a) services in preparation for the non-covered service;

    b) services in connection with providing the non-covered service;

c) hospitalization required to perform the non-covered service; or

d) services that are usually provided following the non-covered service, such as follow up care or therapy after surgery.

- 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 Claims Administrator will be entitled to recover the amount we have allowed for Benefits under the Plan; see *"Plan's Right of Recoupment"* in the ***General Provisions*** section of this benefit booklet. You must provide to us all documents needed to enforce our rights under this provision.

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 Prior Authorization 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 12 months following the date of service for which the 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.

The Claim Administrator's Ownership Interests

The Claim Administrator or its subsidiaries or affiliates may also have ownership interests in or financial arrangements with certain providers who provide Covered Services to Covered Persons, and/or vendors or other third parties who provide services related to the Policy or provide services to certain providers.

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

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

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

Benefits for Services Outside the State of Oklahoma

The Claims Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Arrangements". These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross and Blue Shield Association. Whenever you access Covered Services outside the state of Oklahoma, you will receive it from one of two kinds of Providers. Most Providers ("participating Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some Providers ("non-contracting Providers") do no contract with the Host Blue. We explain below how both types are paid.

- **BlueCard® Program**

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

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

  When you receive Covered Services outside the state of Oklahoma and the claim is processed through the BlueCard® Program, 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 Host Blue makes available to the Claims Administrator.

  Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your health care Provider. Sometimes it is an estimated price that takes into account special arrangements with your health care Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care Providers after taking into account the same types of transactions as with an estimated price.

  Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price we use for your claim because they will not be applied after a claim has already been paid.

- **Non-Participating Providers Outside the Claims Administrator's Service Area**

  — **Liability Calculation**

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

  — **Exceptions**

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

  - the amount calculated using the methodology described in this benefit booklet for non-participating Providers located inside our service area (described above); or

  - the following:

    - for professional Providers, make a payment based on publicly available Provider reimbursement data for the same or similar professional services, adjusted for geographical differences where applicable; or

    - for Hospital or facility Providers, make a payment based on publicly available data reflecting the approximate costs that Hospitals or facilities have incurred historically to provide the same or similar service, adjusted for geographical differences where applicable, plus a margin factor for the Hospital or facility.

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

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

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

- **Blue Cross Blue Shield Global Core**

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

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

— **Inpatient Services**

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

You must contact the Claims Administrator to obtain Prior Authorization for non-emergency Inpatient services.

— **Outpatient Services**

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

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

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

NOTE: The Claims Administrator may postpone application of your Deductible, Copayment and/or Coinsurance amounts whenever it is necessary in order to obtain Provider discounts 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 or if such service or supply is Experimental, Investigational and/or Unproven. The Claims Administrator's medical policies are used as guidelines for coverage determinations in health care Benefits unless otherwise indicated. Medical technology is constantly evolving and these medical policies are subject to change. Copies of current medical policies may be obtained from the 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 were 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 the Plan.

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 the Plan or Claims Administrator.

The Plan does not furnish Covered Services but only provides Benefits for Covered Services you receive from Providers. The Plan is not liable for any act or omission of any Provider. The Plan has no responsibility for a Provider's failure or refusal to give Covered Services to you.

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

Identity Theft Protection Services

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

Coordination of Benefits

All Benefits provided under this Plan 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, group-type, non-group, individual, blanket or franchise insurance coverage;

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

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

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

  — Group or individual automobile insurance coverage; and

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

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

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

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

- **Effect On Benefits**

  If the total Benefits for Covered Services to which you would be entitled under the 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, the Plan will pay Benefits for Covered Services without regard to your coverage under any Other Contract.

  When the Plan is secondary, the Benefits the Plan provides for Covered Services may be reduced because of benefits received from the Other Contracts.

- **Order of Benefit Determination**

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

  — When a Dependent child is covered under two group contracts, the contract covering the child as a Dependent of the parent whose birthday falls earlier 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 coverage will be adjusted accordingly (if the above rules require it).

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

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

- **Facility of Payment**

  If payment is made under any Other Contract which the Plan 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 Plan and the Claims Administrator is discharged from liability to the extent of such amounts paid for Covered Services.

- **Right of Recovery**

  If the Plan pays 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 for Third Party Proceeds**

  To the extent the Plan provides or pays Benefits for Covered Services for any injury, illness or condition which occurs through the omission or commission of any act by another person, each 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, judgement or otherwise from another party or his/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.

Limitations on Plan's Right of Recoupment/Recovery

The Claims Administrator will not seek recovery of all or a portion of a payment of a claim made to a Subscriber more than 12 months or a Provider more than 18 months after the payment is made. This paragraph shall not apply;

- If the payment was made because of fraud committed by the Covered Person or the Provider; or

- If the Covered Person or Provider has otherwise agreed to make a refund to the Plan for overpayment of a claim.

OVERPAYMENTS

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

If no refund is received, your Group's benefit plan and/or Blue Cross and Blue Shield (in its capacity as insurer or administrator) has the right to deduct any refund for any Overpayment due up to an amount equal to the Overpayment, from:

a) Any future benefit payment made to any person or entity under this benefit booklet, whether for the same or a different Member; or

b) Any future benefit payment made to any person or entity under another Blue Cross and Blue Shield administered ASO benefit program and/or Blue Cross and Blue Shield administered insured benefit program or policy, if the future benefit payment owed is to a Network Provider; or

c) Any future benefit payment made to any person or entity under another Blue Cross and Blue Shield insured group benefit plan or individual policy, if the future benefit payment owed is to a Network Provider; or

d) Any future benefit payment, or other payment, made to any person or entity; or

e) Any future payment owed to one or more Network Providers.

Further, the Claims Administrator has the right to reduce your benefit plan's payment to a Network Provider by the amount necessary to recover another Blue Cross and Blue Shield's plan or policy Overpayment to the same Network Provider and to remit the recovered amount to the other Blue Cross and Blue Shield plan or policy.

Claims Filing Procedures

The Plan begins to pay only after any applicable Deductible, Copayment and/or Coinsurance 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 Deductible, Copayment and/or Coinsurance 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 Deductible, Copayment and/or Coinsurance. Then the Claims Administrator's records will show that you have incurred the Deductible, Copayment and/or Coinsurance amount, and your health care coverage will begin to help pay the balance of your eligible expenses.

Participating Providers

Participating Providers, even those outside your network, have agreed to submit claims directly to the 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 use an Out-of-Network Provider who does not file for you, you should follow the guidelines below in submitting your claims.

REMEMBER...

To receive the maximum Benefits under your health care coverage, you must receive treatment from 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 and Other 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 any Deductible, Copayment and/or Coinsurance amounts which apply to your coverage.

Employee-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.

For health claims, you may 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 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 12 months following the date of service for which the 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 our control.

If the Claims Administrator determines that additional time is necessary, you and/or your Provider will be notified, in writing, prior to the expiration of the original 30-day period, that the extension is necessary, along with an explanation of the circumstances requiring the extension of time and the date by which the 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 and/or your Provider, prior to the expiration of the initial 30-day period, of the specific information needed. You will have 45 days from receipt of the notice to provide the additional information. The 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 the number shown on your Identification Card between 8:00 a.m. and 6:00 p.m., Monday through Friday, whenever you have a question concerning a claim or your membership.

Complaint/Appeal Procedure

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 at the number on your Identification Card. In most cases, a Customer Service Representative will be able to provide you with a satisfactory solution to your problem. However, if a resolution cannot be reached in an informal exchange, you may request an administrative review of the problem through our appeal process described below.

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

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. It is suggested 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 as described in "*Claim Appeal Procedures*" below.

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

- The reasons for the determination;
- A reference to the Group Health Plan provisions on which the determination is based, or the contractual or administrative basis or protocol for the determination;
- A description of additional information which may be necessary to perfect the claim and an explanation of why such material is necessary;
- Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care Provider, claim amount (if applicable) and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
- An explanation of the Claims Administrator's internal review/appeals and external review processes (and how to initiate a review/appeal or external review);
- In certain situations, a statement in non-English language(s) that the written notice of the claim denial and certain other Benefit information may be available (upon request) in such non-English language(s);
- In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the Claims Administrator;
- The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for Benefits;
- Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;

- An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances, if the denial was based on Medical Necessity, Experimental, Investigational and/or Unproven treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;
- In the case of a denial of an Urgent Care Claim, a description of the expedited review procedure applicable to such claims. An Urgent Care Claim decision may be provided orally, so long as a written notice is furnished to the claimant within three days of oral notification; and
- Contact information for applicable office of health insurance consumer assistance or ombudsman.

Timing of Required Notices and Extensions

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

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

URGENT CARE CLINICAL CLAIMS*

Type of Notice or Extension	Timing
If your claim is incomplete, the Claims Administrator must notify you within:	**24 hours**
If you are notified that your claim is incomplete, you must then provide completed claim information to the Claims Administrator within:	**48 hours** after receiving notice
The Claims Administrator must notify you of the claim determination (whether adverse or not):	
If the initial claim is complete as soon as possible (taking into account medical exigencies), but no later than:	**72 hours**
After receiving the completed claim(if the initial claim is incomplete), within:	**48 hours**

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

PRE-SERVICE CLAIMS

Type of Notice or Extension	Timing
If your claim is filed improperly, Claims Administrator must notify you within:	**5 days**
If your claim is incomplete, Claims Administrator must notify you within:	**15 days**
If you are notified that your claim is incomplete, you must then provide completed claim information to Claims Administrator within:	**45 days** after receiving notice
The Claims Administrator must notify you of the claim determination (whether adverse or not):	
If the initial claim is complete within:	**15 days***
After receiving the completed claim (if the initial claim is incomplete), within:	**30 days**

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

POST-SERVICE CLAIMS

Type of Notice or Extension	Timing
If your claim is incomplete, Claims Administrator must notify you within:	**30 days**
If you are notified that your claim is incomplete, you must then provide completed claim information to Claims Administrator within:	**45 days** after receiving notice
The Claims Administrator must notify you of the claim determination (whether adverse or not):	
If the initial claim is complete within:	**30 days***
After receiving the completed claim (if the initial claim is incomplete), within:	**45 days**

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

Claim Appeal Procedures

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

  An **"Adverse Benefit Determination"** means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Benefit, including any such denial, reduction, termination, or failure to provide or make payment for, a Benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which Benefits are otherwise provided because it is determined to be

Experimental, Investigational and/or Unproven or not Medically Necessary or appropriate. If an ongoing course of treatment had been approved by the Claims Administrator or your Employer and the Claims Administrator or your Employer reduces or terminates such treatment (other than by amendment or termination of the Employer's Benefit Plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination.

A **"Final Internal Adverse Benefit Determination"** means an Adverse Benefit Determination that has been upheld by the Claims Administrator or your Employer at the completion of the Claims Administrator's or Employer's internal review/appeal process.

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

  If your situation meets the definition of an Expedited Clinical Appeal, you may be entitled to an appeal on an expedited basis. An **Expedited Clinical Appeal** is an appeal of a clinically urgent nature related to health care services, including but not limited to, procedures or treatments ordered by a health care Provider, as well as continued hospitalization. Before authorization of Benefits for an ongoing course of treatment/continued hospitalization is terminated or reduced, 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 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 as soon as possible (taking into account medical exigencies) but no later than 72 hours after it receives the initial request, or within 48 hours after it receives the missing information (if the initial request is incomplete).

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

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

  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 Administrator at the number on the back of your Identification Card.

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

  — Within 180 days after you receive notice of an Adverse Benefit Determination, you may write to your Claims Administrator's Administrative Office. The Claims Administrator will need to know the reasons why you do not agree with the Adverse Benefit Determination. Send your request to:

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

  — 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 Employer.

— If you have any questions about the claims procedures or the review procedure, write to the Claims Administrator's Administrative Office at the address listed above, or call the number shown on your Identification Card.

- ***Timing of Appeal Determinations***

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

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

- ***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 to you or your authorized representative will include:

— A reason for the determination;

— A reference to the Benefit Plan provisions on which the determination is based, and the contractual or administrative basis or protocol for the determination;

— Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care Provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;

— An explanation of the Claims Administrator's external review processes (and how to initiate an external review)

— In certain situations, a statement in non-English language(s) that the written notice of the claim denial and certain other Benefit information may be available (upon request) in such non-English language(s);

— In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the Claims Administrator;

— 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 that decision; and

— Contact information for applicable office of health insurance consumer assistance or ombudsman.

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 four 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 1 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.** If your request is eligible for external review and you submit the request 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 a 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 3 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 10 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.

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 Employer'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 Procedure*** 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.

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 Employer. You are considered Actively at Work on each day of a regular paid vacation, an Employer holiday or on a regular nonworking day if you were Actively at Work on the work day before your Effective Date.

Allowable Charge

The charge that the 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:

- ***For Comprehensive Health Care Services:***
  - — **Network Providers** - the Provider's usual charge, not to exceed the amount the Provider has agreed to accept as payment for Covered Services in accordance with a Network Provider Agreement.
  - — **Out-of-Network (Non-Contracting) Providers** - the lesser of: (a) the Provider's billed charge; or (b) the Claim 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" may be determined by the Blue Cross and Blue Shield Plan (Host Plan) servicing the area. In such case, Benefits will be based upon the Provider payment arrangements in effect between the Provider and the on-site Plan. For information regarding Out-of-Network Provider services, refer to *"Out-of-Area Services"* in the *General Provisions* section for additional information.

Ambulatory Surgical Facility

A Provider with an organized staff of Physicians which:

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

Applied Behavior Analysis

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

Autism Spectrum Disorder

Any of the pervasive developmental disorders or autism spectrum disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the edition that was in effect at the time of diagnosis.

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 Provider

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

Calendar Year

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

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.

Copayment

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

Covered Person

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

Covered Service

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

Custodial Care

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

Deductible

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

Dependent

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

Diagnostic Service

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

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

Durable Medical Equipment

Equipment which meets the following criteria:

- It is used in the Covered Person's home, place of residence or dwelling;
- 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
- 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 an Employee as specified in the ***Eligibility, Enrollment, Changes & Termination*** section.

Emergency Care

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

- serious jeopardy to the Covered Person's health (or, with respect to a pregnant woman, the health of the woman or her unborn child);
- serious impairment to bodily function;
- serious dysfunction of any bodily organ or part; or
- with respect to a pregnant woman who is having contractions:
  - — there is inadequate time to effect a safe transfer to another hospital before delivery, or
  - — transfer may pose a threat to the health or safety of the woman or the unborn child.

Employee

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

Employer

Helmerich & Payne Management, LLC

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/Unproven

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

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

Full-Time Student

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

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

Group

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

Group Health Plan

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

Health Maintenance Organization (HMO)

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

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.

Home Health Care Services

Services provided by a Home Health Care Agency on a part-time, intermittent basis when a Covered Person is confined to his or her home because of disease or injury.

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 addiction or substance 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 the Plan.

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.

Intensive Outpatient Treatment

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

Licensed Practical or Vocational Nurse (LPN or LVN)

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

Life-Threatening Disease or Condition

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

Maternity Services

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

Medical Care

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

Medically Necessary (or Medical Necessity)

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

- in accordance with generally accepted standards of medical practice; and
- 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 the 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.

Network Provider

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

Open Enrollment Period

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

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 Network Provider or BlueCard Provider.

Out-of-Pocket Limit

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

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

Plan

Helmerich & Payne Management, LLC Group Health Plan.

Post-Service Medical Necessity Review

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

Preventive Care Services

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

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

Prior Authorization

The process that determines in advance the Medical Necessity or Experimental, Investigational and/or Unproven nature of certain care and services under the Plan.

Prior Authorization 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.

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.

Recommended Clinical Review

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

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. It does not include half-way houses, wilderness programs, supervised living, group homes, boarding houses or other facilities or programs that provide primarily a supportive environment and address long-term social needs.

Retail Health Clinic

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

Routine Nursery Care

Ordinary Hospital nursery care of the newborn Covered Person.

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 addiction, substance 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 Group's next regular Open Enrollment Period.

Specialist

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

Surgery

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

Therapy Service

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

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









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