BlueCross BlueShield of Oklahoma

To Use or Disclose Protected Health Information (PHI)

Standard Authorization Form

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

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

II. Authorization and Purpose:

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

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

III. Specific Description of Information to be Used or Disclosed

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

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

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

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

Yes ☐

No ☐

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

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

IV. Expiration and Revocation

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

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

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

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

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

_____ _____

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

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

_____ _____

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

_____ _____ _____ _____

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

_____

Personal Representative's Area Code & Telephone Number

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

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

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

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

Prescription Drug Claim Form

BlueCross BlueShield of Oklahoma

See instructions on reverse.

Patient Information

ID Number

Group Number –

Date of Birth / / ❑ Male ❑ Female

Patient Name (First, Last)

Street Address

City State ZIP

Patient's Relationship to Subscriber/Member:

❑ Self ❑ Spouse ❑ Dependent

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

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

Patient/Subscriber/Member or Legal Representative Signature

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

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

If yes, please provide Name of other Insurance: _____

Policy Number: _____

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

Subscriber/Member Information

Name (First, Last)

Pharmacy Information

Pharmacy Name

Pharmacy Address

City State ZIP

Prescription Claim Information

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

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

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

1 Rx Number

Date Filled / /

Quantity _____ Day Supply

Name of Medication _____

NDC Number

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

NPI Number

Prescription Cost $.

Balance Due $.

2 Rx Number

Date Filled / /

Quantity _____ Day Supply

Name of Medication _____

NDC Number

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

NPI Number

Prescription Cost $.

Balance Due $.

3 Rx Number

Date Filled / /

Quantity _____ Day Supply

Name of Medication _____

NDC Number

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

NPI Number

Prescription Cost $.

Balance Due $.

X _____ _____

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

Pharmacy/Prescription Information

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

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

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

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

EXAMPLE
of how to complete the Prescription Drug Claim Form.

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

Date Filled 0 1 / 1 2 / 0 5

Quantity 30 Day Supply 3 0

Name of Medication "Drug Name"

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

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

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

Prescription Cost $ 2 0 5 . 1 4

Balance Due $ 2 0 5 . 1 4

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

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

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

Compound Prescriptions
For pharmacy use only

NDC Number	Drug Ingredient	Quantity	Charge

Rx 1

Pharmacy Receipts Only

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

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

Rx 2

Pharmacy Receipts Only

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

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

3272 OK © Prime Therapeutics LLC 01/12

BlueCross BlueShield of Oklahoma

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

HEALTH BENEFITS CLAIM FORM

SEE INSTRUCTIONS ON REVERSE SIDE

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

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

MEMBER INFORMATION

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

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

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

ACCIDENT INFORMATION

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

DESCRIPTION OF ILLNESS

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

OTHER INSURANCE INFORMATION

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

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

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

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

3.004 (04/06)

Follow these steps for fast, efficient service!

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(please turn to back of page)

COVERAGE

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

EXCLUSIONS FROM COVERAGE

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

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

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

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

LIMITS ON AMOUNT OF COVERAGE

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

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BLUE HEALTH PLANS OF OKLAHOMA

✓ Health Check Basic

Certificate of Benefits

BlueCross BlueShield of Oklahoma

A Member of the Blue Cross and Blue Shield Association,
an Association of Independent Blue Cross and Blue Shield Plans.

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

10.441 (9/06)

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Special Notices

Certificate

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

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

Blue Cross and Blue Shield of Oklahoma (called the Plan, we, us, or our) having issued a Group Contract to the Financial Institution, certifies that all persons who have:

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

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

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

President of Blue Cross and Blue Shield of Oklahoma

Your Subscriber Identification Number: _____

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

Important Information

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

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

YOUR PARTICIPATING PROVIDER NETWORKS

Health Check Basic is a Preferred Provider Organization (PPO) plan that offers the widest choices of network doctors and Hospitals, yet is priced significantly lower than most standard PPO plans. Blue Cross and Blue Shield of Oklahoma has negotiated special agreements with Hospitals, Outpatient facilities, doctors and other health care Providers from many specialties. These participating health care professionals 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 Health Check Basic coverage will provide the highest level of Benefits if you use a BluePreferred Provider whenever possible.

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

HOW YOUR HEALTH CHECK BASIC COVERAGE WORKS

With Health Check Basic, you have the freedom to choose your doctor every time you seek care.

Health Check Basic Subscribers are not required to use a BluePreferred PPO network health care Provider. You'll receive Benefits for Covered Services you receive from health care Providers in other Blue Cross and Blue Shield networks. There are even Benefits if you choose an Out-of-Network Provider. But remember, when you use BluePreferred Providers, Benefits are paid at the highest level. This means less out-of-pocket expense for you. The Coinsurance amount paid by this coverage depends upon which network you use.

Health Check Basic features four different coverage levels:

- **BluePreferred Provider Services** – Most Covered Services are paid at **80%** of the Allowable Charge, after you satisfy any Deductible amounts which may be applicable to your coverage.
- **BlueChoice Provider Services** – Most Covered Services are paid at **70%** of the Allowable Charge, after you satisfy any Deductible amounts which may be applicable to your coverage.
- **BlueTraditional Provider Services** – Most Covered Services are paid at **60%** of the Allowable Charge, after you satisfy any Deductible amounts which may be applicable to your coverage.
- **Out-of-Network Provider Services** – Most Covered Services are paid at **50%** of the Allowable Charge, after you satisfy any Deductible amounts which may be applicable to your coverage. You will also be responsible for any charges which exceed the Plan's allowance for Covered Services.

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 BluePreferred or BlueCard PPO Provider in order to receive the highest level of Benefits under this Certificate. If your Physician prescribes these services, request that he/she refer you to a BluePreferred or BlueCard PPO Provider whenever possible.

SELECTING A PROVIDER

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

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

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

When you call Blue Cross and Blue Shield of Oklahoma, ask our Customer Service Representative whether or not the Provider is a BluePreferred, BlueChoice or BlueTraditional Provider. In the Tulsa area, call (918) 560-3535, and in Oklahoma City, call (405) 841-9596. In other areas, simply call our toll-free number: 1-800-94 BLUES (1-800-942-5837).

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

THE BLUECARD PPO PROGRAM

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

- **Finding a PPO Physician or Hospital**

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

- **Available Care Coast to Coast**

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

- **Remember to Always Carry the BlueCard**

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

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

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

HOW THE BLUECARD PPO PROGRAM WORKS

- ✓ You're outside the state of Oklahoma and need health care.
- ✓ Call 1-800-810-BLUE (2583) for information on the nearest PPO Physicians and Hospitals, or visit the BlueCard Web site at http://www.bluecares.com.
- ✓ You are responsible for Precertification from Blue Cross and Blue Shield of Oklahoma.
- ✓ Visit the PPO Physician or Hospital and present your Identification Card that has the "PPO in a suitcase" logo.
- ✓ The Physician or Hospital verifies your membership and coverage information.
- ✓ After you receive medical attention, your claim is electronically routed to Blue Cross and Blue Shield of Oklahoma, which processes it and sends you a detailed Explanation of Benefits. You're only responsible for meeting your Deductible, Copayment and/or Coinsurance payments, if any.
- ✓ All PPO Physicians and Hospitals are paid directly, relieving you of any hassle and worry.

YOUR PRESCRIPTION DRUG PROGRAM

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

HOW YOUR PRESCRIPTION DRUG PROGRAM WORKS

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

The Participating Pharmacy network includes more than 900 Pharmacies in Oklahoma. Just look for the *LINCS$_{RX}$* symbol on display at your Pharmacy.

In addition, Blue Cross and Blue Shield of Oklahoma Subscribers have instant access to more than 55,000 Pharmacies in the Plan's nationwide Pharmacy network. This extensive network includes most major chains and many independently owned Pharmacies.

REMEMBER -- Using Participating Pharmacies can save you time and money. If you have any questions about your Prescription Drug coverage, please call a Customer Service Representative at one of the following numbers:

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

If you find it necessary to purchase your prescriptions from an Out-of-Network Pharmacy, or if you do not have your Identification Card with you when you purchase your prescriptions, it will be your responsibility to pay the full cost of the Prescription Drugs and to submit a claim form (with your itemized receipt) to receive the Benefits available under the Contract. And, because your pharmacist will not be able to submit your claim electronically, he/she will not be able to apply the *LINCS$_{RX}$* discount for your prescriptions.

MEDICAL NECESSITY LIMITATION

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

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

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

PRECERTIFICATION

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

For an Inpatient facility stay, *you must request Precertification from the Plan* ***before*** *your scheduled admission*. The Plan will consult with your Physician, Hospital, or other facility to determine if Inpatient level of care is required for your illness or injury. The Plan may decide that the treatment you need could be provided just as effectively in a less expensive setting (such as the Outpatient department of the Hospital, an Ambulatory Surgical Facility, or the Physician's office). If the Plan determines that your treatment does not require Inpatient care, you and your Provider will be notified of that decision.

If you proceed with an Inpatient stay without the Plan's approval, or if you do not ask the Plan for Precertification, your Benefits under this Certificate will be reduced by $500 for that admission, provided the Plan determines that Benefits are payable upon receipt of a claim. This reduction applies *in addition to* any penalties associated with your use of an Out-of-Network Provider.

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

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

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

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

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

- **Precertification Requests Involving Urgent Care**

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

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

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

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

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

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

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

- **Precertification Requests Involving Emergency Care**

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

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

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

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

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

CONCURRENT REVIEW AND CASE MANAGEMENT

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

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

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

PRESCRIPTION DRUG PRECERTIFICATION PROCESS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

  – If Precertification is approved for the drug, you may return to the Pharmacy to obtain the full prescription order, subject to any Coinsurance amount applicable to the balance of the drug quantity dispensed.

  – If the Precertification is denied, you may obtain the prescription order by paying the full cost for the drugs.

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

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

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

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

To view a listing of the drugs which are included in the Precertification/Step Therapy program, please visit our Web site at www.bcbsok.com. If you have questions about Step Therapy, or any other aspects of the Precertification process, please call 1-800-94 BLUES (1-800-942-5837) for assistance.

ALLOWABLE CHARGE

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

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

REMEMBER …

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

If you use an Oklahoma Out-of-Network Provider, Blue Cross and Blue Shield of Oklahoma will determine the Allowable Charge for your out-of-network claims ***based upon what we would have reimbursed an Oklahoma BlueChoice Provider for the same service***. You will be responsible for the following:

- Charges for any services which are not covered under your Contract.
- Any Deductible, Copayment and/or Coinsurance amounts which are applicable to your coverage (*including the higher Coinsurance amounts which apply to Out-of-Network Provider services*).
- The difference, if any, between your Provider's "billed charges" and the "Allowable Charge" which a BlueChoice Provider would have accepted for the same services.

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

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

SPECIAL NOTICES

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

Because of changes in federal or state laws, or changes in your Health Check Basic program, "special notices" may be added to your Certificate.

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

IDENTIFICATION CARD

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

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

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

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

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

DESIGNATING AN AUTHORIZED REPRESENTATIVE

The Plan has established procedures for you to designate an individual to act on your behalf with respect to a Benefit claim or an appeal of an adverse Benefit determination. Contact a Customer Service Representative for help if you wish to designate an authorized representative. In the case of a Precertification Request Involving Urgent Care (see page 6), a health care professional with knowledge of your medical condition will be permitted to act as your authorized representative.

QUESTIONS

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

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

Or you can write:

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

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

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

Eligibility, Enrollment, Changes & Termination

This section tells:

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

WHO IS AN ELIGIBLE PERSON

If you are an Oklahoma Resident under age 65, you are eligible to apply for Health Check Basic coverage through your Financial Institution. The Plan reserves the right to request proof of residency upon initial enrollment and from time to time thereafter as the Plan may require.

HOW HEALTH CHECK BASIC WORKS

When you become a Member under Health Check Basic, your coverage is paid automatically, with your authorization, through monthly deductions from your account. These deductions are shown on your regular account statements.

Blue Cross and Blue Shield of Oklahoma dues are deducted from your account on the first day of each month, or the 15th of the month if you select this payment option. If your premium due date falls on a weekend or holiday, your premiums will be deducted on the following business day. Be sure to enter the transaction in your account book.

WHO IS AN ELIGIBLE DEPENDENT

As a Health Check Basic Member, you have the option of selecting coverage under your membership for your Dependent children, or you may purchase separate coverage in their names. If you elect to include them under your membership, an Eligible Dependent is defined as:

- your spouse under age 65; or
- your unmarried child, including a newborn child, adopted child, stepchild, or other child for whom you or your spouse is legally responsible. The limiting age for a Dependent child is:
  - January 1st following the year during which such child attains the age of 19, provided the child has not reached age 19 prior to his or her Effective Date; or
  - the day on which such child attains the age of 23 if regularly attending an accredited secondary school, college or university as a Full-Time Student.

  An unmarried Dependent child who is medically certified as disabled and dependent upon you or your spouse is eligible to continue coverage beyond the limiting age, provided the disability began before the child attained the age of 19, or age 23 in the case of a Full-Time Student.

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

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

WHEN COVERAGE BEGINS

In order to be covered, you must apply for coverage and furnish an acceptable Statement of Health to the Plan for yourself and each of your Eligible Dependents. If the application and Statement of Health are accepted, your Effective Date will be determined by us.

HOW TO ADD DEPENDENTS

You can apply to add Dependents to your coverage at any time. However, an acceptable Statement of Health must be furnished to us for each person to be added to the coverage (see exceptions below for newborn children). If the application and Statement of Health are accepted, the Effective Date will be determined by us.

NEWBORN CHILDREN

If you have a newborn child while covered under Health Check Basic, then the following rules apply:

- If your coverage *does* not include any Dependents, you may add coverage for a newborn, without submitting a Statement of Health, provided application to enroll the newborn is received by the Plan within 31 days of the child's birth. The Effective Date for the newborn will be his/her birth date.
- If your membership includes at least ***one*** Dependent, coverage for the newborn will be effective on the date of birth and continue for 31 days. In order to extend the coverage beyond 31 days, your application to add coverage for the newborn must be received by the Plan within 31 days of the child's birth; and you must make the required contribution for such coverage from the date of birth.
- If your membership already includes *three or more* Dependent children, no application or Statement of Health will be required to add coverage for a newborn child. However, you must notify the Plan of the child's birth. The Effective Date for the newborn will be his/her birth date.
- If you choose ***not*** to enroll a newborn child, coverage for the child will be included under the mother's maternity Benefits for 48 hours following a vaginal delivery, or 96 hours following a cesarean section, ***provided your coverage includes Maternity Coverage which has been in effect for at least 365 days.*** There will be no additional coverage for the newborn child.

ADOPTED CHILDREN

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

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

DELETING A DEPENDENT

You can change your coverage to delete Dependents. The change will be effective at the end of the coverage period for which your dues have been paid, except that:

- in the case of divorce the change will be effective the date the divorce is granted, and
- if a Dependent child marries, coverage for that Dependent will cease on the marriage date; and
- coverage for a Full-Time Student will end on the child's 23rd birthday, or when the child is no longer a Full-Time Student, whichever occurs first.

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

Your spouse and Dependent children become ineligible for Dependent coverage upon your death. However, they may be eligible to change to a new Health Check Basic membership. To ensure continuous protection, we must receive their application within 31 days following your death. Otherwise, a Statement of Health will be required for your spouse and each Dependent child.

WHEN COVERAGE UNDER THIS CERTIFICATE ENDS

When a Subscriber is no longer an Eligible Person or Eligible Dependent, coverage stops at the end of the coverage period for which dues have been paid, except in the following cases:

- When a Subscriber ceases to be an Eligible Dependent by reason of divorce, coverage for that Subscriber will cease on the date the divorce is granted.
- When a Subscriber ceases to be an Eligible Dependent child because he/she has married, coverage for that Subscriber will cease on the marriage date.
- When a Subscriber ceases to be an Eligible Dependent child because he/she has reached the age limit for Dependent children, unless medically certified as disabled, coverage for that Subscriber will end as follows:
  - For a Dependent child who attains the age of 19, coverage will end on the January 1st following the year during which the child attains age 19.
  - For a Dependent child who is a Full-Time Student, coverage will end on the child's 23rd birthday, or when the child is no longer a Full-Time Student, whichever occurs first. It is your responsibility to notify the Plan when your child is no longer enrolled as a Full-Time Student.

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

If your dues are not paid, your coverage will stop at the end of the coverage period for which your dues have been paid. If you do not have sufficient funds on deposit in your Financial Institution, or if the Financial Institution fails to pay your dues, either intentionally or inadvertently, you will be notified by the Plan that your dues were not paid. You will have 10 days from the date of notice to make arrangements with the Plan for reinstatement of your coverage without submitting a Statement of Health.

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

Termination of the Group Contract automatically ends all of your coverage at the same time and date.

WHAT WE WILL PAY FOR AFTER YOUR COVERAGE ENDS

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

- a period of time equal to the length of time you were covered under the Contract; or
- the duration of the Hospital confinement; or
- 90 days following termination of coverage.

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

CERTIFICATES OF COVERAGE

A Certificate of Coverage will be provided, without charge, for individuals who are or were covered under the Contract upon the occurrence of any of the following events:

- **When Coverage Ceases**

  An automatic Certificate of Coverage is to be provided at the time the individual's coverage ceases.

- **Any Individual Upon Request**

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

The Certificate of Coverage gives detailed information about how long you had coverage under the Contract. This information may be used to demonstrate "Creditable Coverage" to your new health plan. Creditable coverage may be used to reduce the preexisting condition exclusion period under the new coverage.

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

CONVERSION PRIVILEGE AFTER TERMINATION OF GROUP COVERAGE

Upon written request to the Plan, you may transfer coverage from Health Check Basic to another Group or to an Individual Conversion contract at any time, subject to the underwriting and enrollment regulations applicable to the new coverage.

If a Subscriber ceases to be an Eligible Dependent, he/she may apply for continuous coverage under an Individual Conversion contract, or under another Health Check Group Contract, subject to the underwriting and enrollment regulations applicable to the new coverage.

If you move to an area serviced by another Blue Cross Plan, you may transfer to the Blue Cross Plan serving that area. *Health Check Basic is available to Oklahoma Residents only.*

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

Written application for a conversion contract must be received by Blue Cross and Blue Shield of Oklahoma no later than 31 days after you cease to be eligible under Health Check Basic.

A conversion contract will not be available to a Subscriber who:

- is eligible for coverage under a Group having a Contract with the Plan; or
- ceases to be eligible due to cancellation of the Group Contract, unless approved by the Plan.

WHEN YOU TURN AGE 65

Coverage under Health Check Basic typically ends at age 65 when Medicare takes over. You may apply for one of the Plan 65 coverage options offered by Blue Cross and Blue Shield of Oklahoma. Plan 65 is a health care program designed to supplement your Medicare coverage.

You may continue to have your Blue Cross and Blue Shield of Oklahoma (Plan 65) dues deducted from your checking or savings account in the same manner as your Health Check Basic dues were deducted.

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

REINSTATEMENT OF COVERAGE FOLLOWING MILITARY ACTIVATION

A Subscriber who is an Oklahoma resident may request reinstatement of coverage under this Certificate if the termination of coverage results from the Subscriber's activation for military service, or from the Subscriber's eligibility for a federal government-sponsored health insurance program resulting from such military activation.

Reinstatement shall be granted, without medical underwriting, into the same coverage the Subscriber held prior to termination, in the same rating tier the Subscriber held prior to activation, and subject to the payment of the current premium charged to other persons of the same age and gender that are covered under the same coverage option.

Except for the birth or adoption of a Dependent child that occurs during the period of activation, reinstatement of coverage must be into the same membership type, or a membership type covering fewer persons, as such Subscriber held prior to lapsing the coverage, and at the same or higher Deductible level.

Reinstatement rights are available only if the Subscriber is an Oklahoma resident and provides written notice to the Plan within 31 days following the later of deactivation or loss of coverage under the federal government-sponsored health insurance program. The Plan may request proof of loss and the timing of the loss of such government-funded coverage in order to determine the Subscriber's eligibility for reinstatement. These reinstatement rights shall not be available to any Subscriber if the activated person is discharged from the military under other than honorable conditions.

HOW YOUR HEALTH CHECK BASIC PREMIUM IS DETERMINED

Health Check Basic, like other insurance coverage, is experience rated. This means that premiums are determined by the actual claims experience of the Health Check Basic Group. And claims experience is a direct

result of the cost of medical care, the number of people who use that care, and how much of it they use. In other words, the more care you use (and others in your Health Check Basic "Group" use) and the more expensive that care is, the higher everyone's premiums must be to cover benefit payments.

Blue Cross and Blue Shield of Oklahoma computes premiums for your Health Check Basic coverage in a way that is fair and equitable for all Members of the Group. These premiums may be adjusted periodically for the entire Health Check Basic Group.

In addition, premiums will change as you and your Dependents change age categories. These adjustments are effective on the first day of the month in which the Subscriber's birthday occurs.

Schedule of Benefits

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

BENEFIT PERIOD

Calendar Year

OFFICE VISIT COPAYMENT

$35 for each visit to the Physician's office. The Copayment applies to charges which are billed as part of your Physician's office visit, except for:

- Surgical services;
- Maternity Services;
- Physical Therapy and Occupational Therapy;
- Chemotherapy;
- Allergy testing and allergy injections;
- Covered childhood immunizations (for Subscribers under age 19);
- Psychiatric Care Services;
- Prescription Drugs;
- Durable Medical Equipment.

The Copayment does not count toward the Deductible or Stop-Loss Limit under this Certificate. In addition, the Copayment will continue to apply to charges Incurred after the Deductible and/or Stop-Loss Limit has been reached.

DEDUCTIBLE

Emergency Room Deductible

$100 for each visit to a Hospital emergency room. This Deductible is waived if you are admitted to the Hospital through the emergency room visit.

Outpatient Surgery Deductible

$200 for each visit to an Outpatient facility for Surgery. This Deductible applies to surgical procedures received in a Hospital Outpatient department or Ambulatory Surgical Facility.

Hospital Admission Deductible

$500 for each visit to a Hospital. This Deductible applies to Covered Services Incurred during the Subscriber's admission to a Hospital except for Routine Nursery Care.

Benefit Period Deductible

$1,000 per Benefit Period per Subscriber.

The Benefit Period Deductible is in addition to the emergency room Deductible, Outpatient Surgery Deductible and Hospital Admission Deductible described above.

The Benefit Period Deductible applies to all Covered Services, except:

- Routine Nursery Care;
- Annual routine gynecological/obstetrical examination and Pap smear;
- Annual prostate cancer screening (limited to $65 per screening);
- Routine Low-Dose Mammography (limited to $115 per screening);
- Covered childhood immunizations (for Subscribers under age 19);
- Prescription Drugs;
- Ambulance Services.

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

FAMILY DEDUCTIBLE

If your coverage includes your Dependents, then:

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

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

The Family Benefit Period Deductible provisions described above do not include the emergency room Deductible, Outpatient Surgery Deductible or Hospital Admission Deductible.

STOP–LOSS LIMIT

When you have Incurred $10,000 ***in excess of any*** Deductible amount for Covered Services during a Benefit Period, the amount of Allowable Charges covered by the Plan on your behalf will

increase to 100% during the remainder of the Benefit Period. This Stop-Loss Limit does not apply to expenses Incurred for:

- Psychiatric Care Services (except for treatment of Severe Mental Illness); or
- Outpatient Prescription Drugs and related services (see special provisions below).

Stop-Loss Limit for Outpatient Prescription Drugs and Related Services

When you have Incurred $20,000 for Outpatient Prescription Drugs and related services during a Benefit Period, the amount of Allowable Charges covered by the Plan on your behalf for such services will increase to 100% during the remainder of the Benefit Period.

This Stop-Loss Limit does not include any expenses which count toward satisfaction of the $10,000 Stop-Loss Limit applicable to other Comprehensive Health Care Services, as set forth above.

MAXIMUM

$5,000,000 per lifetime per Subscriber, including any other limitations specifically stated in this Certificate.

BENEFIT PERCENTAGE

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

COVERED SERVICES (Subject to the *Comprehensive Health Care Services* section which follows)	BENEFIT PERCENTAGE:			
	BluePreferred or BlueCard PPO Provider Services	**BlueChoice Provider Services**	**BlueTraditional Provider Services**	**Out-of-Network Provider Services**
HOSPITAL SERVICES	80%	70%	60%	50%
SURGICAL/MEDICAL SERVICES				
Covered Childhood Immunizations (Limited to Subscribers under age 19)	100%	100%	100%	100%
Annual Routine Gynecological/ Obstetrical Examination and Pap Smear	100%	100%	100%	100%
All Other Covered Surgical/Medical Services	80%	70%	60%	50%
OUTPATIENT DIAGNOSTIC SERVICES				
Routine Low-Dose Mammography (Limited to $115 per screening)	100%	100%	100%	100%
All Other Covered Diagnostic Services	80%	70%	60%	50%
OUTPATIENT THERAPY SERVICES	80%	70%	60%	50%
MATERNITY SERVICES*	80%	70%	60%	50%
MASTECTOMY AND RECONSTRUCTIVE SURGICAL SERVICES	80%	70%	60%	50%
HUMAN ORGAN, TISSUE AND BONE MARROW TRANSPLANT SERVICES	80%	70%	60%	50%

**Benefits for normal pregnancy are available only if Maternity Coverage has been purchased and in effect for at least 365 days before the date the Covered Services are Incurred.*

COVERED SERVICES (Subject to the *Comprehensive Health Care Services* section which follows)	BENEFIT PERCENTAGE:			
	BluePreferred or BlueCard PPO Provider Services	**BlueChoice Provider Services**	**BlueTraditional Provider Services**	**Out-of-Network Provider Services**
AMBULATORY SURGICAL FACILITY SERVICES	80%	70%	60%	50%
PSYCHIATRIC CARE SERVICES				
Covered Services for Treatment of Severe Mental Illness	80%	70%	60%	50%
All Other Covered Psychiatric Care Services	50%	50%	50%	50%
AMBULANCE SERVICES	100%	100%	100%	100%
PRIVATE DUTY NURSING SERVICES	80%	70%	60%	50%
REHABILITATION CARE	80%	70%	60%	50%
SKILLED NURSING FACILITY SERVICES	80%	70%	60%	50%
HOME HEALTH CARE SERVICES	80%	70%	60%	50%
OUTPATIENT PRESCRIPTION DRUGS AND RELATED SERVICES*	50%	50%	50%	50%
ALL OTHER COVERED SERVICES	80%	70%	60%	50%

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

Comprehensive Health Care Services

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

HOSPITAL SERVICES

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

- **Bed and Board**

  Bed, board and general nursing service in:

  – A room with two or more beds;

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

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

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

- **Ancillary Services**

  – Operating, delivery and treatment rooms;

  – Prescribed drugs;

  – Whole blood, blood processing and administration;

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

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

  – Oxygen;

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

  – Diagnostic Services;

  – Therapy Services.

  Benefits for Speech Therapy are limited to Inpatient services only.

- **Emergency Accident Care**

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

- **Emergency Medical Care**

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

- **Surgery**

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

- **Routine Nursery Care**

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

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

SURGICAL/MEDICAL SERVICES

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

- **Surgery**

  Payment includes visits before and after Surgery.

  - If an incidental procedure* is carried out at the same time as a more complex primary procedure, then Benefits will be payable for only the primary procedure. **Separate Benefits will not be payable for any incidental procedures performed at the same time.**
  - When more than one surgical procedure is performed through more than one route of access during one operation, you are covered for:
    - the primary procedure; plus
    - 50% of the amount payable for each of the additional procedures had those procedures been performed alone.
  - Sterilization, regardless of Medical Necessity.

- **Assistant Surgeon**

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

** 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.*

- **Anesthesia**

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

- **Inpatient Medical Services**

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

  – Inpatient Medical Care Visits

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

  – Intensive Medical Care

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

  – Concurrent Care

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

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

  – Consultation

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

  – Newborn Well Baby Care

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

- **Outpatient Medical Services**

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

  – Emergency Accident Care

    Treatment of accidental bodily injuries.

  – Emergency Medical Care

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

  – Home, Office, and Other Outpatient Visits

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

  – Routine Gynecological/Obstetrical Examination and Pap Smear

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

– Contraceptive Devices

Contraceptive devices which are:

° placed or prescribed by a Physician;

° intended primarily for the purpose of preventing human conception; and

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

– Prostate Cancer Screening

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

– Colorectal Cancer Screening

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

– Immunizations, limited to:

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

° Tetanus vaccine;

° Poliomyelitis vaccine;

° Measles virus vaccine;

° Mumps virus vaccine;

° German measles (rubella) vaccine;

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

° Varicella (chicken pox) vaccine;

° Pneumonia vaccine;

° Pneumococcal vaccine;

° Haemophilus influenzae type b (Hib);

° Hepatitis A and hepatitis B vaccine, **limited to Subscribers under age 19;**

° Meningococcal vaccine**, limited to Subscribers under age 19**.

– Child Health Supervision Services

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

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

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

- Audiological Services

  Audiological services and hearing aids, limited to:

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

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

- Bone Density Testing

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

OUTPATIENT DIAGNOSTIC SERVICES

- Radiology, Ultrasound and Nuclear Medicine

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

  - one screening examination every five years for female Subscribers age 35 through 39; and
  - one annual screening examination for female Subscribers age 40 or older.

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

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

OUTPATIENT THERAPY SERVICES

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

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

MATERNITY SERVICES

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

  - Normal Pregnancy

    Your coverage under this Certificate does not include benefits for normal pregnancy.

    Benefits for normal pregnancy are available only if Maternity Coverage has been in effect for at least 365 days before the date the Covered Services are Incurred.

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

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

    - Extrauterine pregnancy;
    - Hyperemesis gravidarum (persistent, severe vomiting of pregnancy);
    - Toxemia with convulsions;
    - Miscarriage or non-elective abortion occurring earlier than the 28th week of a pregnancy;
    - Acute nephritis, nephrosis, cardiac decompensation or missed abortion;
    - Non-elective cesarean section or spontaneous termination of pregnancy, which occurs during the period of gestation in which a viable birth is not possible;
    - Diagnoses represented by ICD-9 Codes (International Classification of Diseases, 9th Edition) which appear under the section entitled "Complications of Pregnancy, Childbirth, and the Puerperium," under headings of Ectopic and Molar Pregnancy and Complications Mainly Related to Pregnancy (except induced abortion and early or threatened labor or late pregnancy), and under subheadings of Postpartum hemorrhage; Retained placenta or membranes, without hemorrhage; Complications of the administration of anesthetic or other sedation in labor and delivery; Shock during or following labor and delivery; Maternal hypotension syndrome; Acute renal failure following labor and delivery; Venous complications in pregnancy and the puerperium (except varicose veins of legs); Pyrexia of unknown origin during the puerperium; or Obstetrical pulmonary embolism;
    - Other conditions requiring intra-abdominal Surgery after termination of pregnancy.
  - Complications of pregnancy shall not include:
    - False labor;
    - Occasional spotting;
    - Physician prescribed rest during the period of pregnancy; or
    - Morning sickness.
  - **Hospital Services and Surgical/Medical Services related to the Subscriber's labor and delivery, by cesarean section or vaginal delivery, will not be covered unless Maternity Coverage has been in force and effect for 365 days prior to the date the services are Incurred, although labor and delivery may result in successful treatment of the complication of pregnancy.**

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

- A minimum of 96 hours of Inpatient care at a Hospital following a delivery by cesarean section for the mother and newborn infant who are covered under this Certificate after childbirth, except as otherwise provided in this section; and
- Postpartum home care following a vaginal delivery if childbirth occurs at home or in a birthing center licensed as a birthing center. The coverage shall provide for one home visit within 48 hours of childbirth by a licensed health care Provider whose scope of practice includes providing postpartum care. The visits shall include, at a minimum:
  - physical assessment of the mother and newborn infant;
  - parent education regarding childhood immunizations;
  - training or assistance with breast or bottle feeding; and
  - performance of any Medically Necessary and appropriate clinical tests.

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

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

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

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

MASTECTOMY AND RECONSTRUCTIVE SURGICAL SERVICES

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

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

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

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

HUMAN ORGAN, TISSUE AND BONE MARROW TRANSPLANT SERVICES

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

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

- **DEFINITIONS**

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

  - **Bone Marrow Transplant**

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

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

- hospitalization, observation and management of reasonably anticipated complications such as graft versus host disease, infections, bleeding, organ or system toxicities and low blood counts.

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

– **High-Dose Chemotherapy**

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

– **High-Dose Radiation Therapy**

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

– **Precertification**

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

– **Procurement Services**

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

- **TRANSPLANT SERVICES**

– **Organ and Tissue Transplant Procedures**

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

- Musculoskeletal transplants;
- Parathyroid transplants;
- Cornea transplants;
- Heart-valve transplants; and
- Kidney transplants.

– **Other Major Organ Transplant Procedures**

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

° Heart Transplants

Benefits will be provided for a heart transplant, provided the Subscriber:

- has terminal heart disease with a life expectancy of 18 months or less;
- has normal liver and kidney function;
- has no concurrent malignancy, HIV (human immunodeficiency virus) infection or AIDS (acquired immunodeficiency syndrome); and
- is psychologically stable and has a supportive social environment.

° Single Lung, Double Lung and Heart/Lung Transplants

Benefits will be provided for a single lung, double lung or heart/lung transplant, provided the Subscriber:

- has end-stage cardiopulmonary or pulmonary disease with a life expectancy of 18 months or less;
- has no concurrent malignancy, HIV infection or AIDS;
- has normal liver and kidney function; and
- is psychologically stable and has a supportive social environment.

° Liver Transplants

Benefits will be provided for a liver transplant, provided the Subscriber:

- has end-stage liver disease with a life expectancy of 18 months or less due to any of the following conditions:
  - extrahepatic biliary atresia;
  - primary biliary cirrhosis;
  - primary sclerosing cholangitis;
  - antigen-negative hepatitis B, antigen-negative or antigen-positive hepatitis C;
  - hepatic vein thrombosis (Budd-Chiari syndrome);
  - certain inborn errors of metabolism (such as Alpha-1-antitrypsin deficiency, Wilson's disease and primary hemochromatosis);
  - primary hepatocellular carcinoma; or
  - primary autoimmune hepatitis;
- has normal kidney function;
- has no concurrent extrahepatic malignancy (including extrahepatic extension or primary hepatocellular carcinoma), HIV infection or AIDS; and
- is psychologically stable and has a supportive social environment.

No Benefits will be provided for a Subscriber with end-stage liver disease as a result of viral hepatitis where the Subscriber remains antigen positive (except for hepatitis C), or whose primary cause of liver damage is secondary to alcohol abuse, unless it can be demonstrated that the Subscriber has abstained from alcohol for a period of no less than 12 months.

- Intestinal Transplants

  Benefits will be provided for a small bowel transplant using a cadaveric intestine for adult and pediatric Subscribers with short-bowel syndrome who have established long-term dependency on total parenteral nutrition and who have developed severe complications due to parenteral nutrition, provided the Subscriber:

  - has no concurrent malignancy, HIV infection or AIDS; and
  - is psychologically stable and has a supportive social environment.

- Small Bowel/Liver or Multivisceral (Abdominal) Transplants

  Benefits will be provided for a small bowel/liver transplant or multivisceral transplant for adult and pediatric Subscribers with short bowel syndrome who have been managed with long-term parenteral nutrition and who have developed evidence of impending end-stage liver failure, provided the Subscriber:

  - has no concurrent malignancy, HIV infection or AIDS; and
  - is psychologically stable and has a supportive social environment.

- Pancreas Transplants

  - Benefits will be provided for a combined pancreas/kidney transplant for diabetic Subscribers with uremia, provided the Subscriber has no concurrent malignancy, HIV infection or AIDS; and is psychologically stable and has a supportive social environment.
  - Benefits will be provided for a pancreas transplant after a prior kidney transplant for Subscribers with insulin dependent diabetes mellitus, provided the Subscriber has no concurrent malignancy, HIV infection or AIDS; and is psychologically stable and has a supportive social environment.
  - Benefits will be provided for a pancreas transplant alone for Subscribers with severely disabling and potentially life-threatening complications due to hypoglycemia unawareness and labile diabetes that persists in spite of optimal medical management, provided the Subscriber has no concurrent malignancy, HIV infection or AIDS; and is psychologically stable and has a supportive social environment.

- Islet Cell Transplants

  Benefits will be provided for an autologous islet cell transplant for Subscribers undergoing total or near total pancreatectomy for intractable pain due to chronic pancreatitis.

– **Bone Marrow Transplants**

Not all autologous or allogeneic Bone Marrow Transplants or stem cell or progenitor cell support procedures, whether performed as independent procedures or in combination with other therapies, e.g., High-Dose Chemotherapy and/or High-Dose Radiation Therapy, are covered.

Benefits for Bone Marrow Transplants are not available for treatment of all conditions, or at all stages of a condition, even if the Provider may recommend such treatment.

Subject to the Exclusions, conditions, and limitations of the Contract, Benefits will be provided for Covered Services rendered by a Hospital, Physician, or other Provider for Bone Marrow Transplants to treat a condition on the Plan's list of approved conditions and medical criteria for eligibility of Benefits (the "Approved List").

If coverage is requested for a Bone Marrow Transplant procedure to treat a condition other than those on the Plan's Approved List, the request will be individually reviewed. If it is determined by the Plan that the transplant is not Medically Necessary for the Subscriber, is Experimental or Investigational, or is otherwise excluded from coverage, Benefits will be denied.

Medical research regarding the effectiveness of Bone Marrow Transplant procedures is ongoing. The Plan periodically reviews conditions to determine eligibility for Benefits. The Subscriber or the treating Provider may obtain the Plan's Approved List of conditions and medical criteria for eligibility for Benefits upon request.

- **EXCLUSIONS AND LIMITATIONS APPLICABLE TO ORGAN/TISSUE/BONE MARROW TRANSPLANTS**
  - In addition to the Exclusions set forth elsewhere in the Contract and this Certificate, no Benefits will be provided for the following organ or tissue transplants or Bone Marrow Transplants or related services:
    - Adrenal to brain transplants.
    - Allogeneic islet cell transplants.
    - High-Dose Chemotherapy or High-Dose Radiation Therapy if the associated autologous or allogeneic Bone Marrow Transplant, stem cell or progenitor cell treatment or rescue is not a Covered Service.
    - Autologous or allogeneic Bone Marrow Transplant and/or stem cell or progenitor cell treatment or rescue with or without High-Dose Chemotherapy or High-Dose Radiation Therapy for breast cancer patients with Stage I, II, or III disease or with refractory Stage IV disease.
    - Tandem transplants for autologous or allogeneic bone marrow or stem cell or progenitor cell treatment or rescue, with or without High-Dose Chemotherapy and/or High-Dose Radiation Therapy, except for a tandem transplant for autologous Bone Marrow or stem cell or progenitor cell treatment or rescue with High-Dose Chemotherapy to treat newly diagnosed or responsive multiple myeloma, only.
    - Small bowel transplants using a living donor.
    - Liver transplant for a Subscriber with end-stage liver disease as a result of viral hepatitis where the Subscriber remains antigen positive (except for hepatitis C), or whose primary cause of liver damage is secondary to alcohol abuse, unless it can be demonstrated that the Subscriber has abstained from alcohol for a period of no less than 12 months.
    - More than one organ of the same type, with the exception of a double-lung transplant done at one time. A heart-only, lung-only, or heart/lung transplant will be considered the same type organ.
    - 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.
    - Any organ or tissue transplant or Bone Marrow Transplant procedure which the Plan considers to be Experimental or Investigational in nature.

- Expenses related to the purchase, evaluation, Procurement Services, or transplant procedure if the organ or tissue or bone marrow or stem cells or progenitor cells are sold rather than donated to the Subscriber recipient.
- All services, provided directly for or relative to any organ or tissue transplant, or Bone Marrow Transplant procedure which is not specifically listed as a Covered Service in this Certificate.

– The transplant must meet the criteria established by the Plan for assessing and performing organ or tissue transplants, or Bone Marrow Transplant procedures.

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

- **DONOR BENEFITS**

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

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

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

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

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

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

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

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

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

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

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

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

AMBULATORY SURGICAL FACILITY SERVICES

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

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

PSYCHIATRIC CARE SERVICES

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

- Inpatient Facility Services

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

- Inpatient Medical Services

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

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

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

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

- Outpatient Psychiatric Care Services
  - Facility and Medical Services

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

  - Day/Night Psychiatric Care Services

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

- Drug Abuse and Alcoholism

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

Benefits for the treatment of any of the following Severe Mental Illnesses shall be equal to the Benefits provided under this Certificate for treatment of all other physical diseases and disorders: schizophrenia; bipolar disorder (manic-depressive illness); major depressive disorder; panic disorder; obsessive-compulsive disorder; and schizoaffective disorder.

Benefits for Psychiatric Care Services related to treatment of a disorder which is not a Severe Mental Illness, as specified above, will not exceed:

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

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

PRIVATE DUTY NURSING SERVICES

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

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

REHABILITATION CARE

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

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

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

SKILLED NURSING FACILITY SERVICES

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

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

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

No Benefits are payable:

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

HOME HEALTH CARE SERVICES

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

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

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

We do not pay Home Health Care Benefits for:

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

HOSPICE SERVICES

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

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

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

DENTAL SERVICES FOR ACCIDENTAL INJURY

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

OUTPATIENT PRESCRIPTION DRUGS AND RELATED SERVICES

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

- Prescription Drugs dispensed for a Subscriber's Outpatient use, when recommended by and while under the care of a Physician or other Provider;
- Injectable insulin and insulin products, but only when dispensed in accordance with a written prescription by a licensed Physician;
- Oral contraceptives, when prescribed by a licensed Physician; and
- Self-injectable Prescription Drugs, when dispensed by a Pharmacy. Self-injectable drugs purchased from a Physician and administered in his/her office are not covered.

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

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

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

DIABETES EQUIPMENT, SUPPLIES AND SELF-MANAGEMENT SERVICES

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

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

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

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

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

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

DURABLE MEDICAL EQUIPMENT

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

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

- It can withstand repeated use and is primarily and customarily used to serve a medical purpose;
- It is generally not useful to a person in the absence of an illness or injury and is appropriate for use in the home; and
- It is prescribed by a Physician and meets the Plan's criteria of Medical Necessity for the given diagnosis.

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

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

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

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

PROSTHETIC APPLIANCES

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

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

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

ORTHOTIC DEVICES

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

Benefits will be provided for the following orthotic devices:

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

Not covered are:

- Arch supports and other foot support devices;

- Elastic stockings;
- Garter belts or similar devices;
- Orthopedic shoes.

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

WIGS OR OTHER SCALP PROSTHESES

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

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

Exclusions

This section lists what is not covered. We want to be sure that you do not expect Benefits that are not included in the Group Contract. It also explains the Preexisting Condition provisions in your coverage.

WHAT IS NOT COVERED

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

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

- 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 which occurs after your Effective Date; or
  - for the improvement of the physiological functioning of a malformed body member, except for services related to Orthognathic Surgery, osteotomy, or any other form of oral Surgery, dentistry, or dental processes to the teeth and surrounding tissue.

  In no event will any care and services for breast reconstruction or implantation or removal of breast prostheses be a Covered Service unless such care and services are performed solely and directly as a result of mastectomy which is Medically Necessary.
- Received from a member of your immediate family.
- Received before your Effective Date.
- For any Inpatient care and services, including rehabilitation care and services, unless documentation can be provided that, due to the nature of the services rendered or your condition, you cannot receive safe or adequate care as an Outpatient.
- Received after your coverage stops.
- For personal hygiene and convenience items regardless of whether or not recommended by a Physician or other Provider. Examples include: computers; air conditioners, air purifiers or filters; humidifiers; or physical fitness equipment, including exercise bicycles or treadmills; or modifications to your home or vehicle.
- For telephone consultations, email or other electronic consultations, missed appointments, or completion of a claim form.
- For Custodial Care such as sitters' or homemakers' services, care in a place that serves you primarily as a residence when you do not require skilled nursing, or for rest cures.
- For foot care only to improve comfort or appearance such as care for flat feet, subluxation, corns, bunions (except capsular and bone Surgery), calluses, toenails, and the like.
- For routine, screening or periodic physical examinations, except as specified in the ***Comprehensive Health Care Services*** section of this Certificate.
- For Maternity Services (except for complications of pregnancy), unless the Member has purchased the optional Maternity Coverage under this Certificate and satisfies the provisions specified in the ***Comprehensive Health Care Services*** section.
- For reverse sterilization.
- For contraceptive medications or devices which are sold without a Physician's prescription (including condoms; contraceptive foam, sponges, or cream; or other spermicides).
- For Orthognathic Surgery, osteotomy, or any other form of oral Surgery, dentistry, or dental processes to the teeth and surrounding tissue (including complications resulting therefrom), except for:
  - the treatment of accidental injury to the jaw, sound natural teeth, mouth or face; or
  - for the improvement of the physiological functioning of a malformed body member.

- Benefits are not provided for dental implants, grafting of alveolar ridges, or for any complications arising from such procedures.
- For or related to Inpatient treatment of any non-covered dental procedure, except that coverage shall be provided for Hospital Services, Ambulatory Surgical Facility Services, and anesthesia services associated with any Medically Necessary dental procedure when provided to a Subscriber who is:
  - severely disabled; or
  - eight years of age or under;

  and who has a medical or emotional condition which requires hospitalization or general anesthesia for dental care.
- For eyeglasses, contact lenses or examinations for prescribing or fitting them, except for aphakic patients (including lenses required after cataract Surgery) and soft lenses or sclera shells to treat disease or injury. Vision examinations not related to the prescription or fitting of lenses will be a Covered Service only when performed in connection with the diagnosis or treatment of disease or injury. Eye refractions are not covered in any event.
- For eye Surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).
- For hearing aids, tinnitus maskers, or examinations for prescribing or fitting them, except as specified for Subscribers 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.
- For Speech Therapy and any related diagnostic testing, except as provided by a Hospital or rehabilitation facility as part of a covered Inpatient stay.
- For transsexual Surgery or any treatment leading to or in connection with transsexual Surgery.
- For diagnosis, treatment or medications for infertility and fertilization procedures. Examples include any form of: artificial insemination; ovulation induction procedures; in vitro fertilization; embryo transfer; or any other procedures, supplies or medications which in any way are intended to augment or enhance your reproductive ability.
- For treatment of sexual problems not caused by organic disease.
- For treatment of obesity, including morbid obesity, regardless of the patient's history or diagnosis, including but not limited to the following: weight reduction or dietary control programs; surgical procedures; prescription or nonprescription drugs or medications such as vitamins (whether to be taken orally or by injection), minerals, appetite suppressants, or nutritional supplements; and any complications resulting from weight loss treatments or procedures.
- For compounded medications. For purposes of this exclusion, "compounded medications" are substances made by mixing, reconstituting or other such acts, not in accordance with directions contained in Food and Drug Administration (FDA) approved labeling provided by the product's manufacturer and other FDA-approved manufacturer directions consistent with that labeling.
- For Prescription Drugs prescribed and used for cosmetic purposes.
- For or related to acupuncture, whether for medical or anesthesia purposes.

- For conditions related to autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems, mental retardation, or for Inpatient confinement for environmental change. This exclusion ***shall not*** apply to the following Medically Necessary services:
  - Physicians' services (except for neuropsychological testing) related to the diagnosis and treatment of attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD) for Subscribers age 19 and under; or
  - Prescription Drug therapy for treatment of ADD/ADHD in Subscribers age 19 and under.
- For family or marital counseling.
- For hippotherapy, equine assisted learning, or other therapeutic riding programs.
- For which the Provider of service customarily makes no direct charge to a Subscriber.
- Received from a Skilled Nursing Facility, Home Health Care Agency, Hospice, or rehabilitation facility which is not a Plan-approved Provider.
- For treatment of temporomandibular joint dysfunction, including but not limited to diagnostic procedures, splints, orthodontic/orthopedic appliances, restorations necessary to increase vertical dimension or to restore or maintain functional or centric occlusion, alteration of teeth or jaws, Physical Therapy, and medication and behavioral modification related to conditions of temporomandibular joint syndrome or any other conditions involving the jaw joint, adjacent muscles or nerves, regardless of cause or diagnosis.
- For or related to transplantation of donor organs, tissues or bone marrow, except as specified under "Human Organ, Tissue and Bone Marrow Transplant Services."
- For Physician standby services.
- For Continuous Passive Motion (CPM) devices used in treatment of the shoulder or other joints, except for up to 21 days postoperatively for the following surgical procedures: total knee arthroplasty, anterior cruciate ligament reconstruction, or open reduction and internal fixation of tibial plateau for distal femur fractures involving the knee joint.
- For ductal lavage of the mammary ducts.
- For extracorporeal shock wave treatment, also known as orthotripsy, using either a high- or low-dose protocol, for treatment of plantar fasciitis and all other musculoskeletal conditions.
- For orthoptic training.
- For thermal capsulorrhaphy as a treatment of joint instability, including but not limited to instability of shoulders, knees and elbows.
- For transcutaneous electrical nerve stimulator (TENS).
- For drug and alcohol treatment that is not rendered in a Hospital or by a psychiatrist, psychologist, licensed clinical social worker or person with a master’s degree in social work.
- For services rendered by licensed professional counselors, marital and family therapists or counselors, or licensed drug and alcohol counselors.
- For services rendered by midwives.

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

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

PREEXISTING CONDITION LIMITATION

Benefits will not be provided for a Preexisting Condition, or for charges relating to a Preexisting Condition, until the date the Subscriber's coverage has been in effect for 12 consecutive months.

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

In the case of a Subscriber who at the time of enrollment under this Certificate was enrolled in any coverage underwritten by Blue Cross and Blue Shield of Oklahoma, the waiting period of 12 months specified above will be ***reduced*** by the period of continuous enrollment preceding enrollment under this Certificate.

EXCLUSION OF COVERAGE RIDER

A Subscriber's coverage under this Certificate may be subject to an "Exclusion of Coverage Rider," which is issued at the time the Subscriber's membership is accepted by the Plan. When a Subscriber receives an Exclusion of Coverage Rider, this means that Benefits will not be provided for any expenses Incurred which relate to or are incident to any condition(s) listed on the rider. Unlike a Preexisting Condition Limitation, the Exclusion of Coverage Rider does not end once the Subscriber has been enrolled for 12 months. The Exclusion of Coverage Rider will remain in force and effect until the Subscriber's coverage terminates, or until the rider is released in writing by the Plan.

General Provisions

This section tells:

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

BENEFITS TO WHICH YOU ARE ENTITLED

We provide only the Benefits specified in this Certificate.

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

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

PRIOR APPROVAL

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

NOTICE AND PROPERLY FILED CLAIM

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

Your Properly Filed Claim must be furnished to the Plan within 90 days after the end of the Benefit Period for which claim is made.

Failure to provide a Properly Filed Claim to the Plan within 90 days 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 two years after expiration of the time within which a Properly Filed Claim is required by the Contract.

PAYMENT OF BENEFITS

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

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

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

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

BENEFITS FOR SERVICES OUTSIDE THE STATE OF OKLAHOMA

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

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

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

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

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

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

DETERMINATION OF BENEFITS AND UTILIZATION REVIEW

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

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

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

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

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

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

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

SUBSCRIBER/PROVIDER RELATIONSHIP

The choice of a Provider is solely yours.

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

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

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

AGENCY RELATIONSHIPS

The Financial Institution is your agent, not our agent.

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

COORDINATION OF BENEFITS

All Benefits provided under the Contract are subject to this provision.

- Definitions

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

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

  – Group, blanket or franchise insurance coverage;

  – Blue Cross Plan, Blue Shield Plan, health maintenance organization, and other prepayment coverage;

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

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

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

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

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

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

- **Effect On Benefits**

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

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

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

- **Order of Benefit Determination**

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

  – When a Dependent child is covered under two group contracts, the contract covering the child as a Dependent of the parent whose birthday falls 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 Plan requests information from another carrier to determine the extent or order of your benefits under an Other Contract, and such information is not furnished after a reasonable time, then the Plan shall:

- Assume the Other Contract is required to determine its benefits first;
- Assume the benefits of the Other Contract are identical to the Benefits of this coverage.

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

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

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

- **Facility of Payment**

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

- **Right of Recovery**

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

PHARMACY BENEFIT ADMINISTRATION

Blue Cross and Blue Shield of Oklahoma contracts with a Pharmacy Benefit Manager (PBM) for certain pharmacy benefit management services, including drug rebate services. Among other contractual services, the PBM negotiates rebate arrangements with drug manufacturers and prepares

and submits drug utilization reports to manufacturers. The PBM, in turn, makes drug rebate payments to Blue Cross and Blue Shield of Oklahoma, which vary based on a number of factors, including the PBM's arrangements with drug manufacturers and the total volume of claims for Prescription Drugs dispensed to Blue Cross and Blue Shield of Oklahoma Subscribers as a group each period. Blue Cross and Blue Shield of Oklahoma applies these payments to general administrative expenses and Prescription Drug benefit administration expenses. Because drug rebates are calculated on a collective, retrospective basis and do not affect the amount charged by or paid to any dispensing pharmacy, rebate payments received by Blue Cross and Blue Shield of Oklahoma do not affect the calculation of the amount of Coinsurance paid by the Subscriber.

PLAN'S RIGHT OF RECOUPMENT

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

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

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

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

LIMITATIONS ON PLAN'S RIGHT OF RECOUPMENT/RECOVERY

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

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

PLAN/ASSOCIATION RELATIONSHIP

Each Subscriber hereby expressly acknowledges its understanding that the Group Contract constitutes a contract solely between the Group and the Plan. The term "the Plan" refers to 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 (the "Association"), an association of independent Blue Cross and Blue Shield Plans. The Association permits the Plan to use the Blue Cross and Blue Shield Service Marks in the State of Oklahoma, and the Plan is not contracting as the agent of the Association. It is further understood that the Group has not entered into the Group Contract based upon representations by any person other than the Plan and that no person, entity, or organization other than the Plan shall be held accountable or liable to the Group or its Subscribers for any of the Plan's obligations to the Group or Subscribers created under the Group Contract. This paragraph shall not create any additional obligations whatsoever on the part of the Plan other than those obligations created under other provisions of the Group Contract.

NOTICE OF ANNUAL MEETING

You are hereby notified that you are a Member of Blue Cross and Blue Shield of Oklahoma, a division of Health Care Service Corporation, a Mutual Legal Reserve Company ("HCSC"), and you are entitled to vote in person, or by proxy, at all meetings of HCSC. The annual meeting is held at our principal office at 300 East Randolph, Chicago, Illinois each year on the last Tuesday in October at 12:30 p.m.

The term "Member" as used above refers only to the person to whom this Certificate is issued. It does not include any other family members covered under family coverage unless such family member is acting on your behalf.

Subscriber Rights

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

You have the right to:

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

Claims Filing Procedures

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

PARTICIPATING PROVIDER NETWORKS

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

REMEMBER...

To receive the maximum Benefits under this Certificate for your Covered Services, you must receive treatment from the *BluePreferred Providers* shown in your directory.

PRESCRIPTION DRUG CLAIMS

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

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

HOSPITAL CLAIMS

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

AMBULATORY SURGICAL FACILITY CLAIMS

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

PHYSICIAN AND OTHER PROVIDER CLAIMS

If you are treated by a Physician or other Provider who does not have an agreement with us, you ordinarily have to pay the bill and then file the claim yourself, along with an itemized statement from

your Physician or other Provider. You will then be paid directly for Covered Services after we subtract your Deductible, Copayment and/or Coinsurance amounts which apply to your coverage.

MEMBER-FILED CLAIMS

When you must file a claim yourself, you may obtain claim forms by contacting the nearest Plan office. Be sure to fill out the claim form completely, sign it, and attach the Provider's itemized statement.

Send the completed form to:

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

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

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

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

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

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

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

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

BENEFIT DETERMINATIONS FOR PROPERLY FILED CLAIMS

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

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

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

notice to provide the additional information. The Plan will notify you of its Benefit determination within 15 days following receipt of the additional information.

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

DIRECT CLAIMS LINE

We have a direct line for claims and membership inquiries. You may call one of the following numbers between 8:00 a.m. and 5:00 p.m., Monday through Friday, whenever you have a question concerning a claim or your membership:

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

Complaint/Appeal Procedure

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

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

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

APPEAL PROCESS (LEVEL I)

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

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

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

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

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

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

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

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

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

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

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

RE-REVIEW PROCESS (LEVEL II)

If you are not satisfied with the decision concerning the appeal, you may elect to submit the adverse Benefit determination to the Plan for re-review. You must exhaust the Appeal Process Level I and the Re-review Process (Level II) before pursuing other legal remedies.

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

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

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

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

EXTERNAL REVIEW (LEVEL III)

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

Definitions

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

ALLOWABLE CHARGE

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

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

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

AMBULATORY SURGICAL FACILITY

A Provider with an organized staff of Physicians which:

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

BENEFIT PERIOD

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

BENEFITS

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

BLUECARD PPO PROVIDER

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

BLUECHOICE PROVIDER

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

BLUEPREFERRED PROVIDER

A Provider who has entered into a BluePreferred Provider Agreement with the Plan to bill the Plan directly for Covered Services, and to accept the Plan's allowance as payment for such Covered Services.

BLUETRADITIONAL PROVIDER

A Provider who has entered into a BlueTraditional Provider Agreement with the Plan to bill the Plan directly for Covered Services, and to accept the Plan's allowance as payment for such Covered Services.

CALENDAR YEAR

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

CERTIFICATE OF COVERAGE

A document providing information which is intended to enable an individual to establish his/her prior Creditable Coverage for the purposes of reducing any preexisting condition exclusion imposed on the individual by any subsequent group health plan coverage.

COINSURANCE

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

COMMUNITY HOME HEALTH CARE AGENCY

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

CONTRACT

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

COPAYMENT

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

COVERED SERVICE

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

CREDITABLE COVERAGE

Coverage of an individual from a wide rage of sources, including group health plans, Individual Health Insurance Coverage, COBRA continuation coverage, Medicare, and Medicaid.

CUSTODIAL CARE

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

DEDUCTIBLE

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

DEPENDENT

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

DEPOSITOR

A person entitled to apply to be a Member by reason of maintaining an account with the Financial Institution and who has been so designated by the Financial Institution.

DIAGNOSTIC SERVICE

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

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

DURABLE MEDICAL EQUIPMENT

Equipment which meets the following criteria:

- It provides therapeutic benefits or enables the Subscriber to perform certain tasks that he or she would be unable to perform otherwise due to certain medical conditions and/or illnesses;
- It can withstand repeated use and is primarily and customarily used to serve a medical purpose;

- It is generally not useful to a person in the absence of an illness or injury and is appropriate for use in the home; and
- It is prescribed by a Physician and meets the Plan's criteria of Medical Necessity for the given diagnosis.

EFFECTIVE DATE

The date when your coverage begins.

ELIGIBLE PERSON

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

EMERGENCY CARE

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

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

EXPERIMENTAL/INVESTIGATIONAL

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

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

FINANCIAL INSTITUTION

The bank, savings and loan association, or credit union which is a party to the Group Contract.

FULL-TIME STUDENT

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

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

GROUP

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

HOSPICE

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

HOSPITAL

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

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

- Place for the provision of rehabilitation care; or
- Place for the treatment of pulmonary tuberculosis.

HOSPITAL ADMISSION

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

IDENTIFICATION CARD

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

INCURRED

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

INDIVIDUAL CONVERSION

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

INDIVIDUAL HEALTH INSURANCE COVERAGE

Health insurance coverage offered to individuals in the individual market, but not including short-term, limited-duration insurance. Individual Health Insurance Coverage can include Dependent coverage.

INPATIENT

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

LICENSED PRACTICAL OR VOCATIONAL NURSE (LPN OR LVN)

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

LOW-DOSE MAMMOGRAPHY

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

MATERNITY COVERAGE

Optional coverage which may be purchased under this Certificate to provide Benefits for Maternity Services. (NOTE: Maternity Coverage is not available to Members under age 19.)

MATERNITY SERVICES

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

MEDICAL CARE

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

MEDICALLY NECESSARY (OR MEDICAL NECESSITY)

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

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

MEDICARE

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

MEMBER

An Eligible Person who has enrolled for coverage.

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.

OKLAHOMA RESIDENT

A person domiciled in the state of Oklahoma. "Domicile" is the place established as your true, fixed and permanent home. It is the place you intend to return to whenever you are away (as on vacation abroad, business assignment, education leave or military assignment). A domicile, once established, remains until a new one is adopted.

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 Plan to be a part of its BluePreferred, BlueChoice, BlueCard PPO or BlueTraditional Provider networks.

OUTPATIENT

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

PARTICIPATING PHARMACY

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

PHARMACY

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

PHYSICIAN

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

PLAN

Blue Cross and Blue Shield of Oklahoma.

PRECERTIFICATION

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

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

PREEXISTING CONDITION

A condition or complication thereof is considered "preexisting" if any of the following events occurred within 12 months before the Subscriber's Effective Date:

- Medical expenses were Incurred; or
- Medical advice or diagnosis was given; or
- Medication was taken or prescribed; or
- Treatment was recommended by or received from a Physician or other Provider; or
- The Subscriber had an awareness of symptoms.

PRESCRIPTION DRUG

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

PROPERLY FILED CLAIM

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

PROVIDER

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

REGISTERED NURSE (RN)

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

ROUTINE NURSERY CARE

Ordinary Hospital nursery care of the newborn Subscriber.

SEVERE MENTAL ILLNESS

Any of the following biologically based Mental Illnesses for which the diagnostic criteria are prescribed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders:

- schizophrenia;
- bipolar disorder (manic-depressive illness);
- major depressive disorder;
- panic disorder;
- obsessive-compulsive disorder; and
- schizoaffective disorder.

SKILLED NURSING FACILITY

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

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

STOP-LOSS LIMIT

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

SUBSCRIBER

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

SURGERY

- The performance of generally accepted operative and other invasive procedures;
- The correction of fractures and dislocations;

- Usual and related preoperative and postoperative care.

THERAPY SERVICE

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

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

TOTAL DISABILITY (OR TOTALLY DISABLED)

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

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

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

BlueCross BlueShield
of Oklahoma

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

AMENDMENT RESPECTING PREMIUM REBATES, PREMIUM ABATEMENTS AND COST-SHARING

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

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

PREMIUM REBATES, PREMIUM ABATEMENTS AND COST-SHARING

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

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

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

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

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

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

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

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

President of Blue Cross and Blue Shield of Oklahoma

BlueCross BlueShield of Oklahoma

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

AMENDMENTS TO THE HEALTH CHECK CONTRACT AND CERTIFICATE OF COVERAGE

IT IS AGREED that the Health Check Contract and the Certificate of Coverage to which this amendment is issued for attachment are amended as set forth below:

A. **AMENDMENT RESPECTING POLICY YEAR**

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

B. **AMENDMENT RESPECTING DEPENDENT ELIGIBILITY**

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

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

C. **AMENDMENT RESPECTING LIFETIME MAXIMUMS**

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

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

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

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

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

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

President of Blue Cross and Blue Shield of Oklahoma

BlueCross BlueShield
of Oklahoma

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

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

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

A. **AMENDMENT RESPECTING ALLOWABLE CHARGE FOR NON-CONTRACTING PROVIDERS**

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

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

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

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

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

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

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

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

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

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

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

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

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

The provisions of this amendment are effective as follows:

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

President of Blue Cross and Blue Shield of Oklahoma

SPECIAL NOTICE REGARDING ADDRESSES, ELIGIBILITY, COVERED SERVICES, EXCLUSIONS, GENERAL PROVISIONS, COMPLAINT/APPEAL PROCEDURE AND DEFINITIONS

Your Certificate of Benefits is amended by the addition of the following special provisions. Unless otherwise specifically stated in this notice, or as required by federal or state regulation, the provisions of this notice are effective February 1, 2010, or your Effective Date, whichever is later.

- **AMENDMENT REGARDING ADDRESSES**

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

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

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

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

- **AMENDMENT REGARDING CONVERSION PRIVILEGES**

  The ***Eligibility, Enrollment, Changes and Termination*** section is amended so that the **"Conversion Privilege After Termination of Group Coverage"** shall not be applicable to the following individuals:

  - a Subscriber who is eligible for coverage under a group having a contract with the Plan; or
  - a Subscriber who ceases to be eligible due to cancellation of the Group Contract.

- **AMENDMENT REGARDING MEDICAL NECESSITY**

  The ***Definitions*** section is amended so that the definition of "Medically Necessary (or Medical Necessity)" is hereby deleted and replaced by the following definition:

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

  – in accordance with generally accepted standards of medical practice;

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

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

- **AMENDMENT REGARDING ORAL CHEMOTHERAPY**

  The ***Covered Comprehensive Health Care Services*** section is amended by the addition of the following special provisions under "**Outpatient Therapy Services**":

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

- **AMENDMENT REGARDING OUTPATIENT THERAPY SERVICES**

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

- **AMENDMENT REGARDING PSYCHIATRIC CARE SERVICES**

  – The ***Covered Comprehensive Health Care Services*** section is amended by the addition of the following special provisions under "**Psychiatric Care Services**"**:**

    ○ "Inpatient Facility Services" are restated to include the following:

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

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

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

  – The ***Definitions*** section is amended by the addition of the following paragraph:

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

    ○ **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.

- **AMENDMENT REGARDING PROSTHETIC APPLIANCES AND ORTHOTIC DEVICES**

  The Benefits specified in this Certificate for "**Prosthetic Appliances**" and "**Orthotic Devices**" are amended to include replacement appliances or devices when Medically Necessary.

- **AMENDMENT REGARDING OUTPATIENT PRESCRIPTION DRUGS AND RELATED SERVICES**

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

– **Brand Name Drug Exclusion**

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

– **Pharmacy Discount Programs**

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

- **AMENDMENT REGARDING EXCLUSIONS**

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

– The following exclusions are hereby removed:

  ○ For drug and alcohol treatment that is not rendered in a Hospital or by a psychiatrist, psychologist, licensed clinical social worker or person with a master's degree in social work.

  ○ For services rendered by licensed professional counselors, marital and family therapists or counselors, or licensed drug and alcohol counselors.

– The following exclusions are hereby added:

  ○ For Inpatient drug and alcohol treatment that is not rendered in a Hospital, Psychiatric Hospital, Residential Treatment Center or other Plan-approved Provider.

  ○ For massage therapy, including but not limited to effleurage, petrissage and/or tapotement.

- **AMENDMENT REGARDING PLAN'S RIGHT OF RECOUPMENT**

The ***General Provisions*** section is amended by the addition of the following provision under "**Plan's Right of Recoupment**":

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

- **AMENDMENT REGARDING COMPLAINT/APPEAL PROCEDURES**

The "***Complaint/Appeal Procedure***" section is amended by a change in the address for filing Level I and/or Level II appeals. Written requests for an appeal should be addressed to:

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

* * * * * * * *

Except as amended, your Certificate remains unchanged.

PLEASE KEEP THIS NOTICE WITH YOUR CERTIFICATE FOR FUTURE REFERENCE.

Special Notice to Health Check Members

Effective July 21, 2008 (or your Effective Date, if later), your Certificate (Benefit Booklet) is amended as set forth below:

❖ The ***Important Information*** provisions of your Certificate are amended as follows:

- **Selecting a Provider**

  A listing of Oklahoma BlueChoice PPO Providers is available on-line through the Blue Cross and Blue Shield of Oklahoma Web site at www.bcbsok.com. You may also call a Customer Service Representative for assistance in locating a network Provider. Simply call our toll-free number: 1-866-520-2507.

- **Questions**

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

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

❖ The ***Eligibility, Enrollment, Changes & Termination*** provisions of your Certificate are amended as set forth below.

- **Who Is an Eligible Person**

  If you are an Oklahoma Resident under age 65, you are eligible to apply for Health Check coverage through your Financial Institution. The Plan reserves the right to request proof of residency upon initial enrollment and from time to time thereafter as the Plan may require.

- **How Health Check Works**

  When you become a Member under Health Check, your coverage is paid automatically, with your authorization, through monthly deductions from your checking or savings account. These deductions are shown on your regular account statements.

  Your initial Health Check premiums are deducted on your coverage Effective Date. Subsequent premiums are deducted from your account on the monthly premium due date. If this due date falls on a weekend or holiday, your premiums will be deducted on the following business day. Be sure to enter the transactions in your account book.

- **Who Is an Eligible Dependent**

  As a Health Check Member, you have the option of selecting coverage under your membership for your Dependents, or you may purchase separate coverage in their names. If you elect to include them under your membership, an Eligible Dependent is defined as:

  – your spouse under age 65 on his/her Effective Date; or

  – your unmarried child, including a newborn child, adopted child or child placed for adoption in your home, stepchild, or other child for whom you or your spouse is legally responsible. A Dependent child is eligible until the end of the billing cycle coinciding with or immediately following the child's 25th birthday, provided the child has not reached age 25 before his/her Effective Date.

    An unmarried Dependent child who is medically certified as disabled and dependent upon the Member or his/her spouse is eligible to continue coverage beyond the limiting age, provided the disability began before the child attained the age of 25.

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

The Plan also reserves the right to review a Physician's certificate of disability and/or request medical records and/or require a medical examination by an independent Physician to verify disability at the Member's expense. The Plan will make the final determination regarding the Dependent's disability status.

- **Deleting a Dependent**

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

  – In the event of a divorce, your spouse may wish to continue Blue Cross and Blue Shield coverage. He/she may apply for equal or lesser Health Check coverage—without submitting a Statement of Health—if his/her application is received by the Plan no later than 60 days after the divorce is granted. Your Dependent children may continue to be eligible under your membership, or your spouse may obtain his/her own Dependent coverage.

  – In the event of your death, your spouse and/or Dependent children may wish to continue Blue Cross and Blue Shield coverage. They may apply for equal or lesser Health Check coverage—without submitting a Statement of Health—if their application is received by the Plan no later than 60 days after your death.

  – A Dependent child who attains the age of 25 is no longer eligible under your coverage (unless medically certified as disabled). The Dependent may apply for equal or lesser Health Check Coverage—without submitting a Statement of Health—if his/her application is received by the Plan no later than 31 days after the end of the coverage period coinciding with or following their 25th birthday.

  If the application for a membership transfer is not received within the time period specified above, a Statement of Health must be submitted and approved by the Plan for the spouse and each Dependent child wishing to enroll.

- **When Coverage Under This Certificate Ends**

  When a Subscriber is no longer an Eligible Person or Eligible Dependent, coverage stops at the end of the coverage period during which eligibility ceases, except that, when a Subscriber ceases to be an Eligible Dependent by reason of death, coverage for that Subscriber will terminate on the date of death.

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

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

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

  Any omission or misstatement of a material fact on your application will result in the cancellation or reformation of your Certificate, retroactive to the Effective Date. In the event of such cancellation, the Plan will refund any premiums paid during the period for which cancellation is effected. However, the Plan will deduct from the premium refund any amounts made in claim payments during this period and you will be liable for any claim payment amounts greater than the total amount of premiums paid during the period for which cancellation is effected.

  At any time when the Plan is entitled to decline to accept an application for coverage or to rescind coverage already in force, the Plan may at its sole option make an offer to reform the Certificate being offered or already in force.

In the event of reformation of a Certificate already in force, the Certificate will be reissued in the form it would have been issued had the misstatement or omitted information been known at the time of the application.

- **Conversion Privilege After Termination of Group Coverage**

  Written application for a conversion contract, or for a transfer to a separate Health Check membership must be received by Blue Cross and Blue Shield of Oklahoma no later than:

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

  – 60 days after the date of the Member's divorce; or

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

❖ The provisions explaining "How Your Health Check Premium is Determined" (in the Important Information or Introduction section) are deleted and replaced by the following provisions:

How Your Health Check Premium Is Determined

Health Check, like other insurance coverage, is experience rated. This means that premiums are determined by the actual claims experience of the Health Check Group. Claims experience is a direct result of the cost of medical care, the number of people who use that care, and how much of it they use. In other words, the more care you use (and others in your Health Check "Group" use) and the more expensive that care is, the higher everyone's premiums must be to cover benefit payments.

Blue Cross and Blue Shield of Oklahoma computes premiums for your Health Check coverage in a way that is fair and equitable for all Members of the Group. These premiums may be adjusted periodically for the entire Health Check Group or as you and/or your Dependents change age categories.

❖ The ***Exclusions*** section is amended so that the "Exclusion of Coverage Rider" provisions are deleted and replaced by the following paragraph:

Coverage Exclusion Rider

A Subscriber's coverage under this Certificate may be subject to a "Coverage Exclusion Rider", which is issued at the time the Subscriber's membership is accepted by the Plan. When a Subscriber is enrolled with a Coverage Exclusion Rider, this means that Benefits will not be provided for any expenses Incurred which relate to any condition(s) listed on the Coverage Exclusion Rider. Unlike a Preexisting Condition Limitation, the Coverage Exclusion Rider does not end once the Subscriber has been enrolled for 12 months. The Coverage Exclusion Rider will remain in force and effect until the Subscriber's coverage terminates, or until the Coverage Exclusion Rider is released in writing by the Plan.

❖ The ***General Provisions*** section is amended so that the "Limitation of Actions" paragraph is deleted and replaced by the following provisions:

Limitation of Actions

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

❖ The "Direct Claims Line" provisions under the "***Claims Filing Procedures***" section are amended as follows:

You may call a Customer Service Representative at 1-866-520-2507 between 8:00 a.m. and 6:00 p.m., Monday through Friday, whenever you have a question concerning a claim or your membership.

❖ The "***Complaint/Appeal Procedure***" section is amended by a change in the address for filing Level I and/or Level II appeals. Written requests for an appeal should be addressed to:

Appeal Coordinator – Customer Service Department
Blue Cross and Blue Shield of Oklahoma
P.O. Box 3238
Naperville, IL 60566-7238

* * * * * * * * * * *

Except as amended, your Certificate remains unchanged.

PLEASE KEEP THIS NOTICE WITH YOUR CERTIFICATE FOR FUTURE REFERENCE.

Special Notice Regarding Human Organ, Tissue and Bone Marrow Transplant Services

Your Certificate (Benefit Booklet) is amended so that the **"Human Organ, Tissue and Bone Marrow Transplant Services"** provisions are deleted in their entirety and replaced by the following:

HUMAN ORGAN, TISSUE AND BONE MARROW TRANSPLANT SERVICES

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

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

DEFINITIONS

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

- **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.

- **Experimental/Investigational**

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

  – The drug, device, biological product, or medical treatment or procedure cannot be lawfully marketed without approval of the appropriate governmental or regulatory agency and approval for marketing has not

been given at the time the drug, device, biological product, or medical treatment or procedure is furnished; or

– The drug, device, biological product, or medical treatment or procedure is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

– The prevailing opinion among peer reviewed medical and scientific literature regarding the drug, device, biological product, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

- **High-Dose Chemotherapy**

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

- **High-Dose Radiation Therapy**

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

- **Precertification**

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

- **Procurement Services**

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

TRANSPLANT SERVICES

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

- Musculoskeletal transplants;
- Parathyroid transplants;
- Cornea transplants;
- Heart-valve transplants;
- Kidney transplants;
- Heart transplants;

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

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

- The transplant must meet the criteria established by the Plan for assessing and performing organ or tissue transplants, or Bone Marrow Transplant procedures, as set forth in the Plan's written medical policies
- In addition to the Exclusions set forth elsewhere in the Contract and the Certificate/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 Plan's written medical policies.
  - Any organ or tissue transplant or Bone Marrow Transplant procedure which the Plan considers to be Experimental or Investigational in nature.
  - Expenses related to the purchase, evaluation, procurement services, or transplant procedure if the organ or tissue or bone marrow or stem cells or progenitor cells are sold rather than donated to the Subscriber recipient.
  - All services, provided directly for or relative to any organ or tissue transplant, or Bone Marrow Transplant procedure which is not specifically listed as a Covered Service in this amendment.
- The transplant must be performed in and by a Provider that meets the criteria established by the Plan for assessing and selecting Providers in the performance of organ or tissue transplants, or Bone Marrow Transplant procedures.

DONOR BENEFITS

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

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

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

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

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

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

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

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

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

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

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

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

LIFETIME MAXIMUM

The Benefits provided under this amendment for human organ and tissue transplant services shall be subject to the same Lifetime Maximum provisions applicable to all other Benefits, as set forth in the Contract and your Certificate/Booklet.

* * * * * * * *

This amendment is effective on January 1, 2008 (or your Effective Date, if later). It supersedes any previous amendment for human organ transplant, tissue transplant and Bone Marrow Transplant services issued to you, and/or any provisions for human organ transplant, tissue transplant and Bone Marrow Transplant services currently reflected in the Contract or your Certificate/Booklet.

Except as amended, your Certificate/Booklet remains unchanged.

PLEASE KEEP THIS NOTICE WITH YOUR CERTIFICATE/BOOKLET FOR FUTURE REFERENCE.

Group Health Service of Oklahoma, Inc.
A Mutual Corporation d.b.a.

BlueCross BlueShield of Oklahoma

A Member of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans.

TULSA
1215 S. Boulder
P.O. Box 3283
Tulsa, OK 74102-3283
(918) 560-3500

OKLAHOMA CITY
3401 N.W. 63rd
P. O. Box 60545
Oklahoma City, OK 73146-0545
(405) 841-9525

HCBasic/$1000/N

10.441 (9/06)

BlueCross BlueShield of Oklahoma

Value-added programs, tools and services are just another advantage of being a Blue Cross and Blue Shield of Oklahoma (BCBSOK) member.

Blue Access for Members℠*

Your gateway to health information

It's easy to register and find what you need at ***bcbsok.com/member****.*

When it comes to managing your health information, it's "easy does it" with our Blue Access for Members (BAM) member site. BAM gives you important health and benefits information that you can manage in one convenient place online.

Go to bcbsok.com, click "Log In" and register to access:

- your personal health history
- benefits highlights, claims, explanations of benefits and forms
- health and wellness resources
- special member discounts and programs

Blue Access Mobile℠

With Blue Access Mobile, you have access to real-time claims status, ID cards and coverage details. Now you can get that information while on the go because BAM is mobile!

** Blue Access for Members is not available on child only policies.*

Provider Finder

Easily search for physicians, specialists and hospitals

It's easy to find physicians, specialists and hospitals with the online Provider Finder. Follow these three steps:

1. Visit bcbsok.com
2. Click Provider Finder
3. Search by network, doctor, hospital or area to find the most up-to-date listing of health care providers

Download the free Provider Finder® App for Android or iPhone

In addition to finding a provider when you're on the go, this app can perform a GPS search and get directions to the provider's location.

70805.0413

Well onTarget℠

Motivation and guidance on the path to health and wellness

The Well onTarget program offers an expanded array of personalized tools and resources designed to plan, engage, motivate, sustain and measure, with the end goal of delivering the best wellness experience to members.

Well onTarget includes wellness programs such as:

- Onmyway™ health assessment
- Health and wellness content
- Liveon wellness member portal
- Fitness program and incentives
- Onmytime self-directed courses

Learn more at wellontarget.com.

BlueCare® Dental PPO

For individuals and families

Something to smile about…
Maximum dental coverage that doesn't take a big bite out of your wallet!

You'll get preventive dental coverage on day one – with no deductible required – for checkups, cleanings and other preventive services. You can choose any dentist you want, with no referrals needed.

By choosing the BlueCare Dental PPO plan from BCBSOK, you can be certain that the savings will add up. In fact, with BlueCare Dental PPO, you'll get one of the highest maximum annual benefit levels available – up to $1,500 per person per year.

For information on eligibility requirements and to sign up for dental coverage that fits your needs, please call us toll-free at 888-454-5590.

Blue365®

Member discount program

Blue365 is just one more advantage of being a BCBSOK member. With this program, you can save money on health care products and services that are most often not covered by your benefit plan. There are no claims to file and no referrals or pre-authorizations.

You can sign up for Blue365, our member discount program that offers deals from brands like Reebok, Jenny Craig® and Nutrisystem®. Log in to Blue Access for Members or visit ***www.Blue365Deals.com/BCBSOK/***.

Davis Vision℠ and TruVision
888-897-9350 or 877-882-2020

Save on eyeglasses as well as contact lenses, laser vision correction services, examinations and accessories. Find out more when you log in to BAM. For a list of Davis Vision providers near you, go to bcbsok.com, click Find a Doctor, then select Find a Vision Provider. The Davis Vision network has major national and regional retail locations as well as independent ophthalmologists and optometrists. You and your eligible dependents can receive discounts on laser vision correction services through the TLC/TruVision network.

Jenny Craig®
877-JENNY70 (877-536-6970)

Jenny Craig can help you reach your weight loss goals. You will get one-on-one support from a trained weight loss expert. Your consultant will give you a tailored program based on the basic components of successful weight management: food, body, mind. You can meet with your consultant in person at a local center. Or you can enjoy the ease of the Jenny Craig At Home program. To get a special savings coupon, log in to BAM.

Life Time® Fitness
Life Time Fitness offers a total health fitness experience no matter your fitness level, interests, schedule or budget. For new members, Life Time Fitness offers a $0 enrollment fee when you sign up online.* Log in to BAM and access the Life Time Fitness website to find a free, seven-day pass to try out the location nearest you.

Procter & Gamble (P&G) Dental Products
877-333-0121

Get savings on dental packages containing the latest in Oral B® power toothbrushes and Crest® products. The dental packages from P&G can help you improve the health of your teeth and gums. Packages may contain items such as an electronic toothbrush, mouth rinse, floss, and many more. To shop in the P&G estore, log in to BAM and click on Member Discounts under Quick Links.

** Proof of Blue Cross and Blue Shield of Oklahoma coverage is needed. The $0 enrollment fee offer is only for new members who enroll online at www.Blue365Deals.com/BCBSOK/. A $35 administrative fee applies to all memberships. Monthly dues and taxes may also apply. Members' prices, dues and fees may change at any time. Offer expires September 1, 2013. Other rules may apply. Always check with the Life Time Fitness club in your area for the most up-to-date offer. Offer not available in Minnesota.*

The relationship between these vendors and Blue Cross and Blue Shield of Oklahoma (BCBSOK) is that of independent contractors.

Blue365 is a discount program only for BCBSOK members. This is NOT insurance. Some of the services offered through this program may be covered under your health plan. Please check your benefit booklet or call the customer service number on the back of your ID card for specific benefit facts. Use of Blue365 does not change your monthly payment, nor do costs of the services or products count toward any maximums and/or plan deductibles. Discounts are only given through vendors who take part in this program. BCBSOK does not guarantee or make any claims or recommendations about the program's services or products. You may want to talk to your doctor before using these services and products. BCBSOK reserves the right to stop or change this program at any time without notice.

Mail service for prescriptions

It's all about convenience

As a BCBSOK member, you have a mail-service prescription drug program available for your maintenance medications. This benefit saves you time and money. Members pay a copayment, coinsurance or a combination, depending on their plan. Just ask your doctor for a written prescription for up to 90 days for each medication you want delivered to your home. You can find more information on BAM under the **My Coverage** tab.

If you have any questions about cost or benefit coverage, call the Blue Cross and Blue Shield Pharmacy Line at 800-423-1973, Monday through Friday, 7 a.m. to 11 p.m., and Saturday and Sunday 7:30 a.m. to 8 p.m. CT. Have your Blue Cross and Blue Shield ID card handy when you call.

Travel with confidence

You're covered!

With our BlueCard® PPO Program, Blue Cross and Blue Shield (BCBS) Plans across the country work together to ensure you receive reliable, affordable health care whenever you're away from home. When you use BlueCard PPO network providers (even while traveling outside your local Plan service area), you will receive the network benefits available through your health plan.

So, when you need medical services outside your local Plan service area, call the customer service telephone number on the back of your ID card. Or call the BlueCard Access telephone number at 800-810-BLUE (2583). The "suitcase" logo on your ID card tells providers that you are part of the BlueCard PPO Program.

Learn more about taking care of your health

Facebook

facebook.com/bluecrossblueshieldofoklahoma

Twitter

twitter.com/bcbsok

YouTube

youtube.com/bcbsok

Blue Cross Blue Shield of Oklahoma

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

This notice describes how Blue Cross and Blue Shield of Oklahoma can use or disclose your medical information and how you can get access to this information. Our contact information can be found at the end of the notice. **Please review this notice carefully.**

YOUR RIGHTS. When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get a copy of your health and claims records	***** You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this by using the contact information at the end of this notice. ***** We will provide a copy or a summary of your health and claims records usually within 30 days of the request. We may charge a reasonable, cost-based fee.
Ask us to correct health and claims records	***** You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this by using the contact information at the end of this notice. ***** We may say "no" to your request. We'll tell you why in writing within 60 days.
Request confidential communications	***** You can ask us to contact you in a specific way or to send mail to a different address Ask us how to do this by using the contact information at the end of this notice. ***** We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	***** You can ask us **not** to share or use certain health information for treatment, payment or our operations. Ask how to do this by using the contact information at the end of this notice. ***** We are not required to agree to your request, and we may say "no" if it would affect your care.
Get a list of those with whom we've shared information	***** You can ask for a list (accounting) for six years prior to your request date of when we shared your information, who we shared it with and why. Ask us how to do this by using the contact information at the end of this notice. ***** We will include all the disclosures except for those about treatment, payment, and our operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but we may charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this notice	***** You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. To request a copy of this notice, use the contact information at the end of this notice and we will send you one promptly.
Choose someone to act for you	***** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. Ask us how to do this by using the contact information at the end of this notice. ***** We confirm the person has the authority and can act for you before we share your information.

BlueCross BlueShield of Oklahoma

YOUR RIGHTS (continued)

File a complaint if you feel your rights are violated	***** You can complain if you feel we have violated your privacy rights by using the contact information at the end of this notice. ***** You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by calling 1-877-696-6775; or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/ or by sending a letter to them at: 200 Independence Ave., SW, Washington, D.C. 20201. ***** We will not retaliate against you for filing a complaint.

YOUR CHOICES. For certain health information, you can tell us your choices about what we share.

If you have a clear preference on how you want us to share your information in the situations described below, tell us and we will follow your instructions. Use the contact information at the end of this notice.

In these cases, you have both the right and choice to tell us to:	***** Share information with your family, close friends, or others involved in payment for your care ***** Share information in a disaster or relief situation ***** Contact you for fundraising efforts

If you cannot share your preference, for example, if you are unconscious, we can share your information if we think it is in your best interest. We may share information when needed to lessen a serious or imminent threat to health or safety.

We *never share your* information in these situations unless you give us written permission	***** Marketing purposes ***** Sale of your information

OUR USES AND DISCLOSURES. How do we use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive	***** We can use your health information and share it with professionals who are are treating you.	***** *Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*
Run our organization	***** We can use and disclose your information to run our organization and contact you when necessary.	***** *Example: We use health information to develop better services for you.*

We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. *This does not apply to long-term care plans.*

Pay for your health services	***** We can use and disclose your health information since we pay for your health services.	***** *Example: We share information about you with your dental plan to coordinate payment for your dental work.*

Administer your plan	***** We may disclose your health information to your health plan sponsor for plan administration purposes.	*******Example: If your company contracts with us to provide a health plan, we may provide them certain statistics to explain the premiums we charge.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways, usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information go to: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	***** We can share your health information for certain situations such as: ***** Preventing disease ***** Helping with product recalls ***** Reporting adverse reactions to medications ***** Reporting suspected abuse, neglect or domestic violence ***** Preventing or reducing a serious threat to anyone's health or safety
Do research	***** We can use or share your information for health research.
Comply with the law	***** We will share information about you when state or federal law requires it, including the Department of Health and Human Services if they want to determine that we are complying with federal privacy laws.
Respond to organ/tissue donation requests and work with certain professionals	***** We can share health information about you with an organ procurement organization. ***** We can share information with a medical examiner, coroner or funeral director.
Address workers' compensation, law enforcement, and other government requests	***** We can use or share health information about you: ***** For workers' compensation claims ***** For law enforcement purposes or with a law enforcement official ***** With health oversight agencies for activities authorized by law ***** For special government functions such as military, national security, and presidential protective services or with prisons regarding inmates.
Respond to lawsuits and legal actions	***** We can share health information about you in response to an administrative or court order, or in response to a subpoena.
Certain health information	***** State law may provide additional protection on some specific medical conditions or health information. For example, these laws may prohibit us from disclosing or using information related to HIV/AIDS, mental health, alcohol or substance abuse and genetic information without your authorization. In these situations, we will follow the requirements of the state law.

OUR RESPONSIBILITIES. When it comes to your information, we have certain responsibilities.

* We are required by law to maintain the privacy and security of your protected health information.
* We will let you know promptly if a breach occurs that compromises the privacy or security of your information.
* We must follow the duties and privacy practices described in this notice and give you a copy of it.
* We will not use or share your information other than as described here unless you tell us we can in writing.

You may change your mind at any time. Let us know in writing if you change your mind.

For more information: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice, and the changes we make will apply to all information we have about you. The new notice will be available upon request or from our website. We will also mail a copy of the new notice to you if there are material changes to our privacy practices.

CONTACT INFORMATION

If you would like general information about your privacy rights or would like a copy of this notice, go to: http://www.bcbsok.com/important_info/index.html. If you have specific questions about your rights or about this notice, you may contact us in one of the following ways:

* Call us at the toll-free number on the back of your member identification card.
* Call us at 1-877-361-7594.
* Write us at:

Divisional Vice President, Privacy Office
Blue Cross and Blue Shield of Oklahoma
P.O. Box 804836
Chicago, IL 60680-4110

EFFECTIVE DATE OF THIS NOTICE

September 23, 2013