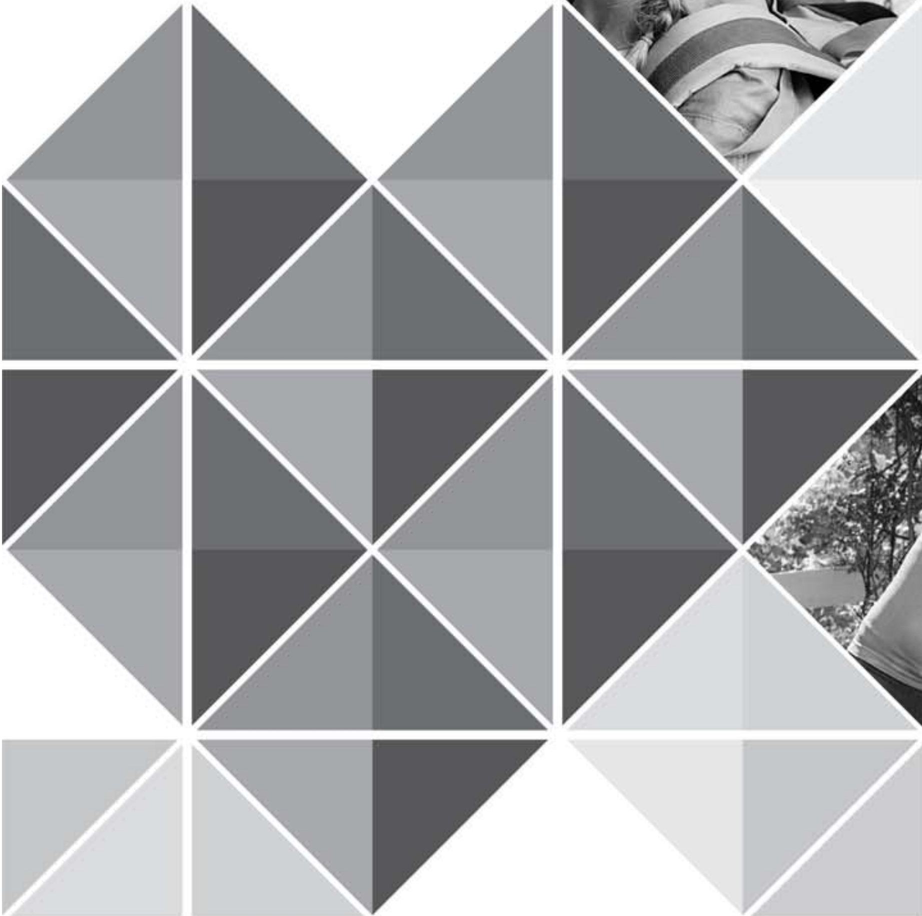

Your Health Care Benefits Program

For Employees of
The Cummins Construction Company, Inc.
Blue Choice PPO^{SM}
January 1, 2018

70260.0516

Blue Choice PPO℠

Blue Choice PPO℠ Network

Schedule of Benefits for Comprehensive Health Care Services

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

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

DEDUCTIBLES	
Benefit Period Deductible	• **Network Provider Services –** $1,000 per Benefit Period per Covered Person, or $2,000 for all covered family members combined. • **Out-of-Network Provider Services –** $1,000 per Benefit Period per Covered Person, or $3,000 for all covered family members combined. Deductible amounts for Network Provider Services and Out-of-Network Provider Services cross-apply. The Benefit Period Deductible applies to all Covered Services, except: • Routine Nursery Care. • Preventive Care Services received from a Network Provider. • Preventive Care Services received from an Out-of-Network Provider are subject to Deductible, except for: — Annual routine gynecological/obstetrical examination and Pap smear; — Annual mammography screening; — Annual prostate cancer screening; — Covered Childhood Immunizations (for Covered Persons under age 19); — Any other state or federally mandated Benefits which stipulate a Deductible may not be required.

OUT-OF-POCKET LIMIT	• **Network Provider Services –** $2,000 per Covered Person, or $5,000 for all covered family members combined. When this limit has been paid (in excess of any Deductible amounts) for Covered Services provided by Network Providers during a Benefit Period, the amount of the Allowable Charges covered by the Plan for such Covered Person will increase to 100% during the remainder of the Benefit Period for Covered Services received from Network Providers. • **Out-of-Network Provider Services –** $2,500 per Covered Person, or $7,500 for all covered family members combined. When this limit has been paid (in excess of any Deductible amounts) for Covered Services provided by Out-of-Network Providers during a Benefit Period, the amount of the Allowable Charges covered by the Plan for such Covered Person will increase to 100% during the remainder of the Benefit Period for Out-of-Network Provider services. Out-of-Pocket Limits for Network Provider Services and Out-of-Network Provider Services cross-apply. This Out-of-Pocket Limit does not include any of the following: • Charges in excess of the Allowable Charge; • Services, supplies or charges limited or excluded by the Plan; • Expenses not covered because a Benefit maximum has been reached; • Any penalty incurred due to your failure to follow the Plan's requirements for Preauthorization, as set forth elsewhere in this benefit booklet.
BENEFIT PERCENTAGE AMOUNT	The following chart shows the percentage of Allowable Charges covered by the Plan through payments and/or contractual arrangements with Providers. These percentages apply only after your Deductible have been satisfied. **NOTE: Any services classified as "Preventive Care Services" are paid at 100% of the Allowable Charge and are not subject to Deductible and/or Coinsurance**

COVERED SERVICES (Subject to the *Comprehensive Health Care Services* section)		
	BENEFIT PERCENTAGE OF ALLOWABLE CHARGES COVERED BY THE PLAN	
	Network Provider Services	**Out-of-Network Provider Services**
EMERGENCY CARE SERVICES	80%	80%[1]
EMERGENCY ACCIDENT CARE (WITH IN 90 DAYS OF ACCIDENT)	100% for the first $500, then 80%[2]	100% for the first $500, then 50%[2]
HOSPITAL SERVICES[3]	80%	50%
SURGICAL/MEDICAL SERVICES		
Physician's Office Visit/Retail Health Clinic Visit	80%	50%
All Other Covered Surgical/Medical Services	80%	50%
Preventive Care Services		
Annual Mammography Screening	100%	100%
Covered Childhood Immunizations	100%	100%
All Other Covered Preventive Care Services	100%	100%
OUTPATIENT DIAGNOSTIC SERVICES	80%	50%
OUTPATIENT THERAPY SERVICES[3] Maximum of 20 Outpatient visits for Physical Therapy per Benefit Period Maximum of 20 Outpatient visits for Occupational Therapy per Benefit Period Maximum of 20 Outpatient visits for Speech Therapy per Benefit Period	80%	50%
MATERNITY SERVICES	80%	50%
MASTECTOMY AND RECONSTRUCTIVE SURGICAL SERVICES	80%	50%

[1] *Treatment in an emergency room for other than Emergency Care, the percentage amount is reduced to 50% of Allowable Charges for services received from Out-of-Network Providers after satisfaction of the Deductible.*

[2] *Deductible waived.*

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

	BENEFIT PERCENTAGE OF ALLOWABLE CHARGES COVERED BY THE PLAN	
	Network Provider Services	**Out-of-Network Provider Services**
HUMAN ORGAN, TISSUE AND BONE MARROW TRANSPLANT SERVICES[1,2] Lifetime Maximum Benefits available for transportation, lodging and meals limited to $10,000 per transplant Daily Maximum Benefits available for transportation and lodging limited to $50 per day Daily Maximum Benefits available for lodging limited to $100 per night	80%	50%
AMBULATORY SURGICAL FACILITY SERVICES	80%	50%
SERVICES RELATED TO TREATMENT OF AUTISM SPECTRUM DISORDER	80%	50%
PSYCHIATRIC CARE SERVICES[1]		
Physician's Office Visit/Retail Health Clinic Visit	80%	50%
All Other Covered Psychiatric Care Services	80%	50%
AMBULANCE SERVICES	80%	80%
PRIVATE DUTY NURSING SERVICES[1]	80%	50%
REHABILITATION CARE[1]	80%	50%
SKILLED NURSING FACILITY SERVICES[1] 30-visit maximum per Benefit Period	80%	50%
HOME HEALTH CARE SERVICES[1]	80%	50%
HOSPICE SERVICES[1]	80%	50%
TEMPOROMANDIBULAR JOINT SYNDROME/DYSFUNCTION	80%	50%
DENTAL SERVICES FOR ACCIDENTAL INJURY	80%	50%
DIABETES EQUIPMENT, SUPPLIES AND SELF-MANAGEMENT SERVICES	80%	50%
DURABLE MEDICAL EQUIPMENT	80%	50%
PROSTHETIC APPLIANCES	80%	50%
ORTHOTIC DEVICES	80%	50%

[1] *All Inpatient Services and certain Outpatient services are subject to Preauthorization approval from the Claims Administrator. See the* ***Important Information*** *section for details regarding "Preauthorization" requirements.*
[2] *Covered Persons are encouraged to use Blue Distinction Centers for Specialty Care for Transplant Services. See the* ***Important Information*** *section of this benefit booklet for additional information.*

	BENEFIT PERCENTAGE OF ALLOWABLE CHARGES COVERED BY THE PLAN	
	Network Provider Services	**Out-of-Network Provider Services**
WIGS OR OTHER SCALP PROSTHESES Maximum of two per Benefit Period	80%	50%
MUSCLE MANIPULATIONS Maximum of 20 visits per Benefit Period	80%	50%
ALL OTHER COVERED SERVICES	80%	50%

Blue Choice PPO℠
Schedule of Benefits
for Outpatient Prescription Drugs and Related Services

This schedule shows any Deductible and/or Coinsurance amounts that apply to the Covered Services described in the ***Outpatient Prescription Drugs and Related Services*** section of your benefit booklet**.** Deductibles, Coinsurance amounts and Out-of-Pocket Limits may be subject to change or increase as permitted by applicable law. **Please note that services must be Medically Necessary, as determined by the Plan, in order to be covered.**

BENEFIT PERIOD	Calendar Year
DEDUCTIBLE	Your Benefits for Outpatient Prescription Drugs and related services are subject to the Benefit Period Deductible set forth in the ***Schedule of Benefits for Comprehensive Health Care Services***.
OUT-OF-POCKET LIMIT	Your Benefits for Outpatient Prescription Drugs and related services are subject to the Out-of-Pocket Limit for "Network Provider Services" set forth in the ***Schedule of Benefits for Comprehensive Health Care Services***.
COINSURANCE	The Coinsurance amount applicable to each Prescription Order is set forth below.
Any pricing difference between the Allowable Charge of a Brand Name Drug and the Allowable Charge of a Generic Drug for which you are responsible does not apply to the Deductible or Out-of-Pocket Limit.	

	Coinsurance Amounts per Prescription Order For Which You Are Responsible	
Retail Pharmacy Program (30-Day Supply)	**Participating Pharmacy**	**Out-of-Network Retail Pharmacy[1]**
Tier 1	10% Coinsurance	10% Coinsurance
Tier 2	20% Coinsurance	20% Coinsurance
Tier 3	20% Coinsurance	20% Coinsurance

	Coinsurance Amounts per Prescription Order For Which You Are Responsible	
Mail-Order Pharmacy Program (90-Day Supply)[2]	**Participating Mail-Order Pharmacy**	**Any Pharmacy other than the Participating Mail-Order Pharmacy[1]**
Tier 1	10% Coinsurance	10% Coinsurance
Tier 2	20% Coinsurance	20% Coinsurance
Tier 3	20% Coinsurance	20% Coinsurance

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

[2] Maintenance Prescription Drugs Only.

Brand Name Drug Selection

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

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

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Plan Summary

The Cummins Construction Company, Inc. (called the ***Employer***) has established and maintains a self-insured Plan of Comprehensive Health Care Benefits (called the ***Plan***) for its eligible Employees and other persons as designated in its personnel policy.

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

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

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

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

This benefit booklet replaces any and all summaries, certificates or benefit booklets previously issued for the Employees under the Plan. It describes the Plan in effect as of January 1, 2018, for all Covered Persons (called "you" or "your").

Important Information

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

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

YOUR PARTICIPATING PROVIDER NETWORK

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

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

HOW YOUR COVERAGE WORKS

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

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

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

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

COST SHARING FEATURES OF YOUR COVERAGE

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

Selecting a Provider

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

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

Blue Distinction Centers for Specialty Care®

Blue Distinction® is a designation given by Blue Cross and Blue Shield companies to Hospitals that have demonstrated expertise in delivering high quality health care. At the core of the Blue Distinction program are the Blue Distinction Centers for Specialty Care and Blue Distinction Centers+ for Specialty Care — facilities that are recognized for their distinguished care in the areas of cardiac care, complex and rare cancer treatment, knee and hip replacement, spinal surgery, bariatric Surgery maternity care, and transplants.

The designation is based on rigorous, clinically meaningful measures (or "selection criteria") established in collaboration with expert Physicians' and medical organizations' input. The program's goal is to help consumers find health care facilities that have demonstrated better overall outcomes (e.g., fewer medical complications, fewer readmissions and higher survival rates) in the delivery of specialty care.

For additional information regarding Blue Distinction Centers for Specialty Care, please contact a Customer Service Representative at the number shown on your Identification Card, or visit the following Web site: www.bcbcs.com/why-bcbs/blue-distinction.

The BlueCard® Program

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

- **Finding a Physician or Hospital**

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

- **Available Care Coast to Coast**

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

- **Remember to Always Carry the BlueCard**

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

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

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

HOW THE BLUECARD PROGRAM WORKS

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

YOUR PRESCRIPTION DRUG PROGRAM

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

Blue Cross and Blue Shield of Oklahoma has contracted with a network of Participating Pharmacies to help control the increasing costs of Prescription Drugs. When you present your Identification Card to your Participating Pharmacy, your claim will be processed electronically. Your pharmacist will be able to tell immediately which charges count toward your Deductible and/or Coinsurance and/or Coinsurance amounts and will collect the appropriate amount from you at the time of purchase. The Pharmacy will then be reimbursed directly by the Plan for the balance of the Allowable Charges.

HOW YOUR PRESCRIPTION DRUG PROGRAM WORKS

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

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

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

Medically Necessary or 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 coverage provides Benefits for Covered Services that are determined by the Claims Administrator to be Medically Necessary. **"Medically Necessary" is generally defined as health care services that a Hospital, Physician or other Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:**

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

Preauthorization

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

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

If you utilize a Network Provider for Covered Services, that Provider **may** request Preauthorization for the services. However, it is ***the Covered Person's*** responsibility to assure that the services are Preauthorized before receiving care. You or your Provider may request Preauthorization by calling the Preauthorization number shown on your Identification Card ***before*** receiving treatment.

- **Preauthorization Process for Inpatient Services**

  For an Inpatient facility stay, *you must request Preauthorization from the Claims Administrator as soon as possible, but no later than one business day* ***before*** *your scheduled admission*. The Claims Administrator will consult with your Physician, Hospital, or other facility to determine if Inpatient level of care is required for your illness or injury. The Claims Administrator may decide that the treatment you need could be provided just as effectively in a different setting (such as the Outpatient department of the Hospital, an Ambulatory Surgical Facility, or the Physician's office). If the Claims Administrator determines that your treatment does not require Inpatient care, you and your Provider will be notified of that decision.

  If you proceed with an Inpatient stay without the Claims Administrator's approval, or if you do not ask the Claims Administrator for Preauthorization, your Benefits under the Plan will be reduced, as described below under "*Failure to Preauthorize*", provided the Claims Administrator determines that Benefits are available upon receipt of a claim. This reduction applies *in addition to* any Benefit reduction associated with your use of an Out-of-Network Provider, if applicable.

  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).

- **Preauthorization Process for Inpatient Psychiatric Care Services**

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

- **Preauthorization Requests Involving Emergency Care**

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

- **Preauthorization Process for Certain Outpatient Services**

  Preauthorization is also required for the following **Outpatient** Psychiatric Care Services:

  — Psychological testing;

  — Neuropsychological testing;

  — Electroconvulsive therapy;

  — Intensive Outpatient Treatment;

  — Repetitive Transcranial Magnetic Stimulation.

- **Response to Preauthorization Requests**

  The Claims Administrator will provide a written response to your Preauthorization request no later than 15 days following the date they receive your request. This period may be extended one time for up to 15 additional days, if the Claims Administrator determines that additional time is necessary due to matters beyond its control.

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

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

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

- **Response to Preauthorization Requests Involving Urgent Care**

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

— could seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function; or

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

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

The Claims Administrator's response to your "*Preauthorization 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.

- **Failure to Preauthorize**

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

  If the Covered Person fails to obtain Preauthorization for the Outpatient Psychiatric Care Services specified above:

  — the Claims Administrator will review the Medical Necessity of the treatment or service prior to the final Benefit determination.

  — If the Claims Administrator determines the treatment or service is not Medically Necessary or is Experimental/Investigational, Benefits will be reduced or denied.

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

Concurrent Review

Whenever it is determined that Inpatient care or an ongoing course of treatment may no longer be Medically Necessary, you, your Provider or your authorized representative may submit a request to the Claims Administrator for continued services. If you, your Provider or your authorized representative requests to extend care beyond the approved time limit and it is a Request Involving Inpatient Urgent Care or an ongoing course of treatment, the Claims Administrator will make a determination on the request/appeal as soon as possible (taking into account medical exigencies) but no later than 72 hours after it receives the initial request, or within 48 hours after it receives the missing information (if the initial request is incomplete).

What To Do In An Emergency

In the case of an emergency, when you get immediate medical assistance from a Hospital, Physician or other Provider that best meets the needs of your emergency, those Covered Services will receive the maximum allowable Benefits based upon the Allowable Charge for those services. If you use an Out-of-Network Provider for your Emergency Care, you will not be subject to the higher Coinsurance amount nor the Out-of-Network Hospital Deductible normally associated with your use of an Out-of-Network Provider.

It should be noted here that simply because care or treatment is received in an emergency department, it does not automatically qualify as Emergency Care. Emergency Care is defined as treatment for an injury, illness or condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a reasonable and prudent layperson could expect the absence of medical attention to result in:

- serious jeopardy to the Covered Person's health;
- serious impairment to bodily function; or

- serious dysfunction of any bodily organ or part.

Allowable Charge

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

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

- The Claims Administrator will calculate your Benefits based on this "Allowable Charge". They will deduct any charges for services which are not eligible under your coverage, then subtract any Deductible and/or Coinsurance amounts which may be applicable to your Covered Services. They will then determine your Benefits under the Plan, and direct any payment to your Network Provider.

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

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

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

  1. the Provider's billed charges; or

  2. the Claims Administrator's Non-Contracting Allowable Charge.

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

  For services for which a Medicare reimbursement rate is not available, the Allowable Charge for Non-Contracting Providers will represent an average contract rate for Network Providers adjusted by a predetermined factor established by the Claims Administrator and updated on a periodic basis. Such factor shall not be less than 90% of the average contract rate. The Claims Administrator will utilize the same claim processing rules and/or edits that it utilizes in processing Participating Provider claims for processing claims submitted by Non-Contracting Providers which may also alter the Allowable Charge for a particular service. In the event the Claims Administrator does not have any claim edits or rules, the Claims Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the claims. The Allowable Charge will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific claim, including but not limited to, disproportionate share and graduate medical education payments.

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

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

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

  1. the median amount negotiated with network or contracting Providers for the Emergency Care Services furnished;

  2. the amount for the Emergency Care Services calculated using the same method the Claims Administrator generally uses to determine payments for Out-of-Network Provider services, but substituting the in-network or contracting cost-sharing provisions for the Out-of-Network or Non-Contracting Provider cost sharing provisions; or

  3. the amount that would be paid under Medicare for the Emergency Care Services.

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

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

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

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

Special Notices

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

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

Be sure to check for "special notices". It changes provisions or Benefits in your Plan.

Identification Card

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

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

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

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

DESIGNATING AN AUTHORIZED REPRESENTATIVE

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

QUESTIONS

Whenever you call the Claims Administrator's offices for assistance, please have your Identification Card with you.

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

Or you can write to:

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

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

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

Eligibility, Enrollment, Changes & Termination

This section tells:

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

WHO IS AN ELIGIBLE PERSON

Your are an Eligible Person if you satisfy the eligibility requirements specified by your Employer, as set forth in the Plan.

The Plan contains information about the health care benefit program for the persons in your Plan who:

- A full time Employee is a person who is scheduled to work a minimum of 30 hours per week and who is on the permanent payroll of the Employer;
- Have applied for this coverage; and
- Have received a Blue Cross and Blue Shield of Oklahoma Identification Card.

If you meet this description of an Eligible Person, you are entitled to the Benefits of this Plan.

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

WHO IS AN ELIGIBLE DEPENDENT

An Eligible Dependent is defined as:

- your spouse.
- your Dependent child. Wherever used in this benefit booklet, “Dependent child” means your natural child, a stepchild, an eligible foster child, an adopted child or child Placed for Adoption (including a child for whom you, your spouse 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 Covered Person or spouse is also considered a Dependent child under the Group Health Plan, provided proof of dependency is provided with the child’s application.

  — Dependent children are eligible for coverage until the end of the month following their 26th birthday.

  — Dependent children who are medically certified as disabled and dependent upon you or your spouse are eligible for coverage regardless of age, provided the disability began before the child attained the age of 26.

If two Eligible Persons are married to each other, one may Enroll as an Employee and the other as a Dependent, or both may Enroll as Employees. Their child or children may be covered as Dependents under either person's coverage, but not both.

How to Enroll

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

Initial Enrollment Period

- **Initial Group Enrollment**

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

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

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

- **Initial Enrollment of New Dependents**

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

  — **Newborn Children**

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

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

IMPORTANT:

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

— **Adopted Children**

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

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

SPECIAL ENROLLMENT PERIODS

The Group Health Plan includes Special Enrollment Periods during which individuals who previously declined coverage are allowed to Enroll (without having to wait until the next Open Enrollment Period). A Special Enrollment Period can occur if a person with other health coverage loses that coverage or if a person becomes a Dependent through marriage, birth, adoption, or Placement for Adoption.

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

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

  — You and/or your Dependent must otherwise be eligible for coverage under the terms of the Plan.

  — When the coverage was previously declined, you and/or your Dependent must have been covered under another Group Health Plan or must have had other health insurance coverage.

  — When you declined enrollment for yourself or for your Dependent(s), you stated in writing that coverage under another Group Health Plan or other health insurance coverage was the reason for declining enrollment. This paragraph applies only if:

  ○ the Plan required such a statement when you declined enrollment; and

  ○ you are provided with notice of the requirement to provide the statement in this paragraph (and the consequences of your failure to provide the statement) at the time you declined enrollment.

  — When you declined enrollment for yourself or for your Dependent under the Plan:

  ○ you and/or your Dependent had COBRA Continuation Coverage under another plan and COBRA Continuation Coverage under that other plan has since been exhausted; or

  ○ if the other coverage that applied to you and/or your Dependent when enrollment was declined was not under a COBRA Continuation provision, either the other coverage has been terminated as a result of loss of eligibility for the coverage or employer contributions towards the other coverage have been terminated.

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

"Loss of eligibility for coverage" includes a loss of coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, and any loss of eligibility after a period that is measured by reference to any of the foregoing. Loss of eligibility does not include a loss due to failure of the individual or the participant to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or any intentional misrepresentation of a material fact in connection with the plan).

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

- **Special Enrollment For New Dependents**

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

— You may Enroll when you marry or have a new child (as a result of marriage, birth, adoption or Placement for Adoption).

— Your spouse can be enrolled separately at the time of marriage or when a child is born, adopted or Placed for Adoption.

— Your spouse can be enrolled together with you when you marry or when a child is born, adopted or Placed for Adoption.

— A child who becomes your Dependent as a result of marriage, birth, adoption or Placement for Adoption can be enrolled when the child becomes a Dependent.

— Similarly, a child who becomes your Dependent as a result of marriage, birth, adoption or Placement for Adoption can be enrolled if you Enroll at the same time.

— Coverage with respect to a marriage is effective no later than first day of the month after the date the request for enrollment is received.

— Coverage with respect to a birth, adoption or Placement for Adoption is effective on the date of birth, adoption or Placement for Adoption.

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

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

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

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

— The Employee's or Dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility; or

— The Employee or Dependent becomes eligible for a Group Health Plan premium assistance subsidy under Medicaid or CHIP.

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

Health Plan premium assistance subsidy under Medicaid or CHIP. Coverage under special enrollment will be effective no later than the first day of the month after the Plan receives the special enrollment request.

Open Enrollment Period

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

Qualified Court Orders for Medical Coverage for Dependent Children

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

The order must include specific information such as:

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

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

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

Delayed Effective Date

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

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

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

Deleting a Dependent

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

COBRA* Continuation Coverage

- **Eligibility for Continuation Coverage**

  When a Qualifying Event occurs, eligibility under this Plan may continue for you and/or your Eligible Dependents (including your widow/widower, your divorced or legally separated spouse, and your children) who were covered on the date of the Qualifying Event. A child who is born to you, or Placed for Adoption with you, during the period of COBRA Continuation Coverage is also eligible to elect COBRA Continuation Coverage.

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

  — your divorce or legal separation; or

  — your Dependent child ceasing to be an Eligible Dependent under the Plan; or

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

- **Election of Continuation Coverage**

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

  — the date the Qualifying Event would cause you or your Dependent to lose coverage; or

  — the date your Employer notifies you, or your Eligible Dependent, of your COBRA Continuation Coverage rights.

- **COBRA Continuation Coverage Period**

  You and/or your Eligible Dependents are eligible for coverage to continue under the Plan coverage for a period not to exceed:

  — 18 months from the date of a loss in coverage resulting from a Qualifying Event involving your termination of employment or reduction in working hours; or

  — 36 months from the date of a loss in coverage resulting from a Qualifying Event involving:

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

    ○ the ineligibility of a Dependent child;

  provided the premiums are paid for the coverage as required.

- **Disability Extension**

  — COBRA Continuation Coverage may be extended from 18 months to 29 months for you or an Eligible Dependent who is determined by the Social Security Administration to have been disabled on the date of a Qualifying Event, or within the first 60 days of COBRA Continuation Coverage. This 11-month disability extension is also available to nondisabled family members who are entitled to COBRA Continuation Coverage.

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

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

- **Multiple Qualifying Events**

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

- **Special TAA/ATAA Election Period**

  An Employee who loses his/her job due to a trade-related reason may be entitled to a second 60-day COBRA election period if the Employee did not elect COBRA Continuation Coverage when initially eligible to do so. In order to qualify for this election period, the U. S. Department of Labor (or a state labor agency) must issue a certification showing that the job loss was due to trade-related reasons and that the Employee is entitled to "trade adjustment assistance" (TAA) or "alternate trade adjustment assistance" (ATAA). The special 60-day election period begins on the first day of the month in which the Employee becomes eligible for trade adjustment assistance, as determined by the Department of Labor or state labor agency. The Employee is not eligible for the special election period if the TAA/ATAA eligibility determination is made more than six months after termination of employment.

WHEN COVERAGE UNDER THIS PLAN ENDS

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

- A Covered Person's COBRA Continuation Coverage, when applicable, will cease at the end of the month coinciding with or next following the earliest to occur of the following dates:

  — the date the coverage period ends following expiration of the 18-month, 29-month, or 36-month COBRA Continuation Coverage period, whichever is applicable;

  — the first day of the month that begins more than 30 days after the date of the Social Security Administration's final determination that the Covered Person is no longer disabled (when coverage has been extended from 18 months to 29 months due to disability);

  — the date on which the Employer stops providing any Group Health Plan to any Employee;

  — the date on which coverage stops because of a Covered Person's failure to pay any contribution required for the COBRA Continuation Coverage;

  — the date on which the Covered Person first becomes (after the date of the election) covered under any other Group Health Plan which does not contain any exclusion or limitation with respect to a preexisting condition applicable to the Covered Person (or the date the Covered Person has satisfied the preexisting condition exclusion period under that plan); or

  — the date on which the Covered Person becomes (after the date of the election) entitled to benefits under Medicare.

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

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

Comprehensive Health Care Services

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

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

EMERGENCY CARE SERVICES

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

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

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

HOSPITAL SERVICES

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

- **Bed and Board**

  Bed, board and general nursing service in:

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

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

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

  Outpatient emergency Hospital services and supplies to treat injuries caused by an accident.
- **Emergency Medical Care**

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

  Hospital services and supplies for Outpatient Surgery furnished by an employee of the Hospital or other Provider other than the surgeon or assistant surgeon.
- **Routine Nursery Care**
  - — Inpatient Hospital Services for Routine Nursery Care of a newborn Covered Person.
  - — Routine Nursery Care does not include treatment or evaluation for medical or surgical reasons during or after the mother's maternity confinement. In the event the newborn requires such treatment or evaluation while covered under the Plan:
    - ○ the infant will be considered as a Covered Person in its own right and will be entitled to the same Benefits as any other Covered Person under the Plan; and
    - ○ a separate Deductible will apply to the newborn's Hospital confinement.

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

SURGICAL/MEDICAL SERVICES

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

- **Surgery**

  Benefits include visits before and after Surgery.

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

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

  - ○ the primary procedure; plus

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

- — Sterilization, regardless of Medical Necessity.

- — Oral Surgery

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

- **Assistant Surgeon**

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

- **Anesthesia**

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

- **Inpatient Medical Services**

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

  - — Inpatient Medical Care Visits

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

  - — Intensive Medical Care

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

  - — Concurrent Care

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

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

  - — Consultation

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

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

— Newborn Well Baby Care

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

- **Outpatient Medical Services**

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

— Emergency Accident Care

Treatment of accidental bodily injuries.

— Emergency Medical Care

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

— Home, Office and Other Outpatient Visits

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

— Preventive Care Services

Services performed by a Provider as "routine" or "screening" services. Routine or screening examinations which meet the guidelines for mandated Benefits, established by Oklahoma state law, shall not be included as Preventive Care Services, but shall be subject to the limitations specified elsewhere in this benefit booklet.

Unless specifically provided by Oklahoma state law, the following services are not included:

- ◦ Hearing or vision screening examinations;
- ◦ Medical supplies or equipment;
- ◦ Routine foot care.

— 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 Covered Persons, including a prostate-specific antigen blood test and a digital rectal examination, limited to one screening exam per Benefit Period.

— Colorectal Cancer Screening

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

— 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);
- Rotavirus vaccine, **limited to Covered Persons under age 19**;
- Human papillovirus vaccine (HPV), **limited to Covered Persons under age 19**;
- Hepatitis A and hepatitis B vaccine, **limited to Covered Persons under age 19**;
- Meningococcal vaccine, **limited to Covered Persons under age 19**;
- Any other immunization required for children by the Oklahoma State Board of Health.

— 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 are limited to Covered Persons under age 19.

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.

— Infertility Treatment

Diagnosis of infertility. Treatment, including Surgery, is not covered.

— Chiropractic Medical Services

Services for chiropractic care are limited to the office visit and X-rays when provided by a Chiropractor and are limited to the number of visits specified in the ***Schedule of Benefits for Comprehensive Health Care Services***.

— Muscle Manipulations

Outpatient Diagnostic Services

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

Outpatient Therapy Services

- Radiation Therapy

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

- Chemotherapy

  Oral Chemotherapy and self-injectable/self-administered Chemotherapy are covered under the *Outpatient Prescription Drugs and Related Services* section, if applicable.

- Respiratory Therapy
- Dialysis Treatment
- Infusion Therapy
- Physical Therapy, Speech Therapy and Occupational Therapy

  Benefits for Outpatient Physical Therapy, Speech Therapy and Outpatient Occupational Therapy (including visits to the Covered Person's home) are limited to the number of visits specified in the Schedule of Benefits for Comprehensive Heath Care Services.

Maternity Services

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

  — Normal Pregnancy

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

  — Complications of Pregnancy

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

  — Interruptions of Pregnancy

  ○ Miscarriage.

- Abortion, when the mother's life is endangered.
- Therapeutic Abortion

- Covered Maternity Services include the following:

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

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

- Inpatient care shall include, at a minimum:

  - physical assessment of the mother and newborn infant;
  - parent education regarding childhood immunizations;
  - training or assistance with breast or bottle feeding; and
  - performance of any Medically Necessary and appropriate clinical tests.

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

  - The licensed health care Providers determine that the mother and newborn infant meet medical criteria contained within guidelines, developed by or in cooperation with licensed health care Providers, which recognize treatment standards, including, but not limited to, the most current treatment standards of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, that determine the appropriate length of stay based upon:
    - evaluation of the antepartum, intrapartum and postpartum course of the mother and newborn infant;
    - the gestational age, birth weight and clinical condition of the newborn infant;
    - the demonstrated ability of the mother to care for the newborn infant postdischarge; and
    - the availability of postdischarge follow-up to verify the condition of the newborn infant in the first 48 hours after delivery; and
  - The Plan covers one home visit, within 48 hours of discharge, by a licensed health care Provider whose scope of practice includes providing postpartum care. Such visits shall include, at a minimum:

- physical assessment of the mother and newborn infant;
- parent education regarding childhood immunizations;
- training or assistance with breast or bottle feeding; and
- performance of any Medically Necessary and appropriate clinical tests.

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

Maternity Services for Dependent children are not covered, 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 lymphedema.

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

HUMAN ORGAN, TISSUE AND BONE MARROW TRANSPLANT SERVICES

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

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

Certain transplants must be obtained through facilities designated as Blue Distinction Centers for Specialty Care, in order to obtain the highest level of Benefits under this Plan. Refer to the *Schedule of Benefits for additional information*.

- **Definitions**

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

— **Bone Marrow Transplant**

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

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

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

— **High-Dose Chemotherapy**

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

— **High-Dose Radiation Therapy**

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

— **Preauthorization**

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

— **Procurement Services**

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

- **Transplant Services**

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

— Musculoskeletal transplants;

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

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

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

- **Donor Benefits**

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

  — When both the recipient and the living donor are Covered Persons, each is entitled to the Benefits of the Plan.

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

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

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

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

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

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

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

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

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

  — The Bone Marrow Transplant is not excluded by another provision of the Plan.

AMBULATORY SURGICAL FACILITY SERVICES

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

- Such services are Medically Necessary;

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

Services Related to Treatment of Autism Spectrum Disorder

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

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

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

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

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

Psychiatric Care Services

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

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

- Inpatient Facility Services

  Covered Inpatient Hospital Services provided by a Hospital, Psychiatric Hospital, Residential Treatment Center or other Plan-approved Provider (including partial hospitalization programs).

- Inpatient Medical Services

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

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

  — Individual Psychotherapy;

  — Group Psychotherapy;

  — Psychological Testing; and

  — Convulsive Therapy Treatment.

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

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

- Outpatient Psychiatric Care Services

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

- Drug Abuse and Alcoholism

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

AMBULANCE SERVICES

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

  — From your home to a Hospital;

  — From the scene of an accident or medical emergency to a Hospital;

  — Between Hospitals;

  — Between a Hospital and a Skilled Nursing Facility; or

  — From the Hospital to your home.

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

PRIVATE DUTY NURSING SERVICES

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

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

Rehabilitation Care

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

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

Skilled Nursing Facility Services

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

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

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

No Benefits are available:

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

Home Health Care Services

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

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

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

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

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

The Plan does not pay Home Health Care Benefits for:

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

Hospice Services

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

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

Temporomandibular Joint Syndrome/Dysfunction

Surgical treatment of temporomandibular joint (TMJ) dysfunction or any other conditions involving the jaw joint, adjacent muscles or nerves, regardless of cause or diagnosis.

Dental Services for Accidental Injury

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

Diabetes Equipment, Supplies and Self-Management Services

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

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

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

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

  Diabetes self-management training and training related to medical nutrition therapy, when provided by a registered, certified, or licensed health care professional, shall also include home visits when Medically Necessary and shall include instruction in medical nutrition therapy only by a licensed registered 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 (for example: *under"Durable Medical Equipment", "Orthotic Devices"* and *"Home Health Care Services").*

DURABLE MEDICAL EQUIPMENT

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

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

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

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

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

Prosthetic Appliances

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

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

Orthotic Devices

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

Benefits will be provided for the following orthotic devices:

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

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

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

Wigs or Other Scalp Prostheses

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

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

WEIGHT LOSS TREATMENT

Services for treatment of obesity and morbid obesity including office visits, diagnostic services and weight loss Surgery.

EYE SURGERY

Charges for radial keratotomy and Lasik eye Surgery, to correct refractive errors, are covered up to a max of $5,000 per eye calendar year.

Outpatient Prescription Drugs and Related Services

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

COVERED SERVICES

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

- Prescription Drugs dispensed for a Covered Person's Outpatient use, when recommended by and while under the care of a Physician or other Provider.
- Injectable insulin and insulin products, but only when dispensed in accordance with a written prescription by a licensed Physician or other Provider even though a prescription may not be required by law.
- Oral contraceptives, when prescribed by a licensed Physician or other Provider.
- Prescription Drugs prescribed for treatment of attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD), subject to the Plan's requirements for *"Preauthorization"*.
- Oral Chemotherapy when prescribed by a licensed Physician. Coverage of prescribed orally administered anticancer medications will be provided on a basis no less favorable than intravenously administered or injected cancer medications.
- Self-injectable and other self-administered Prescription Drugs (including Chemotherapy), when dispensed by a Pharmacy. Self-administered drugs purchased from a Physician and administered in his/her office are not covered. Many self-injectable/self-administered drugs are classified as "Specialty Pharmacy Drugs" and may be purchased from a Participating Specialty Pharmacy.
- Specialty Pharmacy Drugs (when dispensed by a Pharmacy participating in the Specialty Pharmacy Network), **limited to a 30-day supply per Prescription Order**.
- Select vaccinations (when administered by a Participating Retail Pharmacy Vaccination Network Provider). For a current listing of vaccines available through this coverage, call Customer Service at the number listed on your Identification Card or visit the Claim Administrator's Web site at www.bcbsok.com.
- Drugs prescribed by a Physician or other Provider as part of "Preventive Care Services" as defined in this benefit booklet (including both prescription and over-the-counter drugs) which have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF") or as required by state law. Drugs obtained for Preventive Care will be provided in the quantities and within the time periods allowed under applicable law. Such drugs are not subject to the Deductible and/or Coinsurance provisions of the Plan when obtained from a Participating Pharmacy.
- Tier 1 – includes mostly Generic Drugs and may contain some Brand Name Drugs.
- Tier 2 – includes mostly Preferred Brand Name Drugs and may contain some Generic Drugs.
- Tier 3 – includes mostly Non-Preferred Brand Name Drugs and may contain some Generic Drugs.

Retail Pharmacy Program

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

Extended Prescription Drug Supply Program

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

Benefits will not be provided for more than a 90 day supply of drugs obtained from a Prescription Drug Provider *not* participating in the Extended Prescription Drug Supply Program.

Mail-Order Pharmacy Program

The Mail-Order Pharmacy Program provides delivery of covered Maintenance Prescription Drugs directly to your home address. If you and your covered Dependents elect to use the mail order service, refer to the ***Schedule of Benefits for Outpatient Prescription Drugs and Related Services*** for applicable payment levels.

You are encouraged to fill these Maintenance Prescription Drugs through the Mail-Order Pharmacy.

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

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

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

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

Payment of Benefits

- Benefits are provided for Prescription Drugs dispensed for a Covered Person's Outpatient use when recommended by and while under the care of a Physician or other Provider, provided such care and treatment is Medically Necessary.
- Benefits for Prescription Drugs are available to the Covered Person only:
  - in accordance with a Prescription Order; and
  - after the Covered Person has met the Deductible, if applicable; and

— after the Covered Person has incurred charges equal to the Coinsurance applicable to each Prescription Order. **If the charge for your Prescription is *less* than your Coinsurance, you will pay the lesser amount.**

- When Prescription Drugs and related services are dispensed by a Participating Pharmacy the Claims Administrator will pay directly to the Pharmacy the Allowable Charge for the drugs, less the applicable Deductible and/or Coinsurance specified in the ***Schedule of Benefits for Outpatient Prescription Drugs and Related Services***.

- If your Prescription Order is filled by an Out-of-Network Pharmacy, you will need to pay the full cost of the drugs directly to the Pharmacy and then submit a claim to the Claims Administrator in order to receive any Benefits under this program. In addition to any Coinsurance and/or Deductible amounts applicable to your coverage, you will be responsible for the cost difference, if any, between the Pharmacy's billed charges and the Allowable Charge determined by the Plan. **NOTE: Vaccinations administered by a Pharmacy that is not a Participating Retail Pharmacy Vaccination Network Provider are not covered under this *Outpatient Prescription Drugs and Related Services* section**.

PRESCRIPTION DRUG SUPPLY/DISPENSING LIMITS

The Plan has the right to determine the day supply or unit dosage limits at its sole discretion. Benefits may be denied if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the stated maximum supply limitations.

- **Benefit Supply Limits per Prescription Order**

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

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

  — **Retail Pharmacy and Specialty Pharmacy Network Providers —** During each one-month period, up to a 30-day supply or 120 units (e.g. pills), whichever is less, for "non-maintenance" and Specialty Pharmacy Drugs.

  — **Extended Prescription Drug Supply Program and Mail-Order Pharmacy Program —** During each three-month period, up to a 90-day supply or 360 units (e.g. pills), whichever is less, for drugs designated by the Plan as maintenance prescription drugs. If less than a 90-day supply is ordered, the extended retail supply or mail-order Coinsurance will still apply.

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

  Benefits will not be provided for a prescription refill until 75% of the previous Prescription Order has been used by the Covered Person.

  If you are leaving the country or need an extended supply of medication, call Customer Service at least two weeks before you intend to leave. Extended supplies of vacation overrides are not available through the Mail-Order Pharmacy Program but may be approved through a retail Pharmacy only. In some cases, you may be asked to provide proof of continued enrollment eligibility under this Prescription Drug program.

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

  In addition to the supply limits stated above and regardless of the quantity of a Covered Drug prescribed by a Physician, the Plan has the right to establish dispensing limits on Covered Drugs. These limits, which are based upon FDA dosing recommendations and nationally recognized clinical guidelines, identify gender or age

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

- **Controlled Substances Limitation**

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

THERAPEUTIC EQUIVALENT RESTRICTIONS

Some drugs are manufactured under multiple names and have many therapeutic equivalents. In such cases, the Claims Administrator may limit Benefits to specific therapeutic equivalents. If you do not accept the therapeutic equivalents that are covered under your Prescription Drug program, the drug purchased will not be covered under any Benefit level.

EXCLUSIONS AND LIMITATIONS

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

- Non-FDA approved drugs.
- Drugs which by law do not require a Prescription Order from an authorized Provider (except insulin, insulin analogs, insulin pens and prescriptive and nonprescriptive oral agents for controlling blood sugar level); and drugs, insulin or covered devices for which no valid Prescription Order is obtained.
- Devices or Durable Medical Equipment of any type (even though such devices may require a Prescription Order), such as, but not limited to, contraceptive devices, therapeutic devices, artificial appliances or similar devices (**except** lancets, test strips, and disposable hypodermic needles and syringes for self-administered injections). However, coverage for prescription contraceptive devices is provided under the ***Comprehensive Health Care Services*** section of your Benefit Booklet.
- Pharmaceutical aids such as excipients found in the USP-NF (United States Pharmacopeia-National Formulary) including, but not limited to, preservatives, solvents, ointment bases, and flavoring, coloring, diluting, emulsifying and suspending agents.
- Administration or injection of any drugs (except for select vaccines administered by a Participating Pharmacy).
- Vitamins (**except** those vitamins which by law require a Prescription Order and for which there is **no** non-prescription alternative).
- Drugs dispensed in a Physician's office or during confinement while a patient in a Hospital, or other acute care institution or facility, including take-home drugs; and drugs dispensed by a nursing home or custodial or chronic care institution or facility.

- Covered Drugs, devices, or other Pharmacy services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, including but not limited to, any services or supplies for which benefits are payable under Part A and Part B of Title XVIII of the Social Security Act (Medicare), or the laws, regulations or established procedures of any county or municipality, except any program which is a state plan for medical assistance (Medicaid), or any Prescription Drug which may be properly obtained without charge under local, state, or federal programs, unless such exclusion is expressly prohibited by law; provided, however, that this exclusion shall not be applicable to any coverage held by you for Prescription Drug expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.

- Any services provided or items furnished for which the Pharmacy normally does not charge.

- Infertility and fertility medications;

- Drugs required by law to be labeled: "Caution — Limited by Federal Law to Investigational Use", or Experimental, Investigational and/or Unproven drugs, even though a claim is made for the drugs.

- Covered Drugs or devices dispensed in quantities in excess of the amounts stipulated in this ***Outpatient Prescription Drugs and Related Services*** section; or refills of any prescriptions in excess of the number of refills specified by the Physician or by law; or any drugs or medicines dispensed more than one year following the Prescription Order date.

- Drugs which are not approved by the U.S. Food and Drug Administration (FDA) for a particular use or purpose or when used for a purpose other than the purpose for which the FDA approval is given, except as required by law or regulation. This exclusion is not applicable to the coverage of the off-label use of Prescription Drugs for the treatment of cancer or the study of oncology in accordance with Oklahoma law.

- Fluids, solutions, nutrients, medications (including all additives and Chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous, intramuscular (in the muscle), intrathecal (in the spine), or intraarticular (in the joint) injection in the home setting, except as specifically provided in this the benefit book. NOTE: This exception does not apply to dietary formula necessary for the treatment of phenylketonuria (PKU) or other heritable diseases.

- Drugs the use or intended use of which would be illegal, unethical, imprudent, abusive, not Medically Necessary or otherwise improper.

- Drugs obtained by unauthorized, fraudulent, abusive or improper use of the Identification Card.

- Rogaine, Minoxidil or any other drugs, medications, solutions or preparations used or intended for use in the treatment of hair loss, hair thinning or any related condition, whether to facilitate or promote hair growth, to replace lost hair or otherwise.

- Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.

- Drugs used or intended to be used in the treatment to stimulate growth, including but not limited to, self-administered injectable drugs.

- Athletic performance enhancement drugs.

- Replacement of drugs or other items that have been lost, stolen, destroyed or misplaced.

- Shipping, handling or delivery charges.

- Institutional packs and drugs which are repackaged by anyone other than the original manufacturer.

- Nonsedating antihistimine drugs and combination medications containing a nonsedating antihistamine and decongestant.
- Proton pump inhibitors.
- Drugs determined by the Claims Administrator to have inferior efficacy or significant safety issues.
- Diagnostic agents, except diabetic testing supplies or test strips.
- Bulk powders.
- Any self-administered drugs dispensed by a Physician.

PRESCRIPTION DRUG PRIOR AUTHORIZATION AND STEP THERAPY PROCESS

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

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

You can obtain a listing of the drugs which require Prior Authorization or Step Therapy by contacting a Customer Service Representative at the number shown on your Identification Card. Or, you may request a listing by writing to:

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

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

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

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

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

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

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

Prime Therapeutics
P.O. Box 25136
Lehigh Valley, PA 18002-5136

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

To view a listing of the drugs which are included in the Prior Authorization/Step Therapy program, please visit the Claims Administrator's Web site at www.bcbsok.com. If you have questions about Step Therapy or Prior Authorization, please call a Customer Service Representative at the number shown on your Identification Card for assistance.

Note: Prior Authorization and Step Therapy will be effective from March 1, 2018.

Exclusions

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

WHAT IS NOT COVERED

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

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

- Any services, supplies or drugs provided to a Covered Person incurred outside the United States if the Covered Person traveled to the location for the purposes of receiving medical services, supplies or drugs.
- For cosmetic Surgery or complications resulting therefrom, including Surgery to improve or restore your appearance, unless:
  - — needed to repair conditions resulting from an accidental injury; or
  - — for the improvement of the physiological functioning of a malformed body member resulting from a congenital defect.

  In no event will any care and services for breast reconstruction or implantation or removal of breast prostheses be a Covered Service unless such care and services are performed solely and directly as a result of mastectomy which is Medically Necessary.
- Received from a member of your immediate family.
- Received before the Covered Person's Effective Date.
- Received after the Covered Person's coverage stops.
- For any Inpatient care and services, including rehabilitation care and services, unless documentation can be provided that, due to the nature of the services rendered or your condition, you cannot receive safe or adequate care as an Outpatient.
- For personal hygiene and convenience items regardless of whether or not recommended by a Physician or other Provider. Examples include: computers; air conditioners, air purifiers or filters; humidifiers; or physical fitness equipment, including exercise bicycles or treadmills; or modifications to your home or vehicle.
- For telephone consultations, email or other electronic consultations (except electronic consultations occurring with a Provider in connection with a "medical home" program that has been approved by the Plan), missed appointments or completion of a claim form.
- For Custodial Care such as sitters' or homemakers' services, care in a place that serves you primarily as a residence when you do not require skilled nursing.
- For foot care only to improve comfort or appearance such as care for flat feet, subluxation, corns, bunions (except capsular and bone Surgery), calluses, toenails, and the like.
- For routine, screening or periodic physical examinations which are not included as *"Preventive Care Services",* as specified in the ***Comprehensive Health Care Services*** section of this benefit booklet.
- For reverse sterilization.
- For female contraceptive devices when not prescribed by a licensed Provider, including over-the-counter contraceptive products. Contraceptive medications or devices for male use are excluded.
- For 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 resulting from a congenital defect;
  - — dental extractions performed in preparation for radiation treatment for neoplasms involving the jaw/mouth; or

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

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

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

— severely disabled; or

— eight years of age or under, and who has a medical or emotional condition which requires hospitalization or general anesthesia for dental care; or

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

- For eyeglasses, contact lenses or examinations for prescribing or fitting them, except for:

— aphakic patients (including lenses required after cataract Surgery) and soft lenses or sclera shells to treat disease or injury; or

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

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

- For 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 dysfunction not caused by organic disease.

- For tobacco cessation programs (not including counseling or medications as specified under *"Preventive Care Services"*).

- For medication, drugs or hormones to stimulate growth.

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

- For conditions related to hyperkinetic syndromes, learning disabilities, mental retardation or for Inpatient confinement for environmental change. This exclusion ***shall not*** apply to the following Medically Necessary services:

— Services of a Physician or other Provider (except for neuropsychological testing) related to the diagnosis and treatment of attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD); or

— Prescription Drug therapy (provided the Plan includes Benefits for Outpatient Prescription Drugs) for treatment of ADD/ADHD.

- For unspecified developmental disorders or autistic disease of childhood, except as specified in the ***Comprehensive Health Care Services*** section under *"Services Related to Treatment of Autism Spectrum Disorder"*.

- For hippotherapy, equine assisted learning or other therapeutic riding programs.

- For which the Provider of service customarily makes no direct charge to a Covered Person.
- Received from a Skilled Nursing Facility, Home Health Care Agency, Hospice or rehabilitation facility which is not a Plan-approved Provider.
- For 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 elective abortion, unless the life of the mother is endangered.
- For Inpatient drug and alcohol treatment that is not rendered in a Hospital, Psychiatric Hospital, Residential Treatment Center or other Plan-approved Provider.
- For massage therapy, including but not limited to effleurage, petrissage and/or tapotement.
- For marital counseling.
- Which are not specifically named as Covered Services subject to any other specific exclusions and limitations in this benefit booklet.

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

General Provisions

This section tells:

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

BENEFITS TO WHICH YOU ARE ENTITLED

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

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

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

PRIOR APPROVAL

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

NOTICE AND PROPERLY FILED CLAIM

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

Your Properly Filed Claim must be furnished to the Claims Administrator within 12 months following the date of service for which the claim is made.

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

LIMITATION OF ACTIONS

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

PAYMENT OF BENEFITS

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

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

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

Benefits under this Plan will be based upon the Allowable Charge (as the Claims Administrator determines) for Covered Services. A Network Provider may collect any Deductible and/or Coinsurance amounts applicable to your coverage, but you will not be responsible for any amounts that exceed the Allowable Charge for Covered Services. **However, if you receive Covered Services from an Out-of-Network Provider, you may be responsible for amounts which exceed the Allowable Charge, in addition to any Deductible and/or Coinsurance amounts which may apply.**

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

Benefits for Services Outside the State of Oklahoma

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

- **BlueCard® Program**

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

  When you receive Covered Services outside the state of Oklahoma and the claim is processed through the BlueCard Program, the amount you pay for Covered Services is calculated on the lower of:

  — The billed charges for your Covered Services; or

  — The negotiated price that the Host Blue makes available to the Claims Administrator.

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

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

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

- **Liability Calculation**

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

- **Exceptions**

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

  - the amount calculated using the methodology described in this benefit booklet for non-participating Providers located inside our service area (described above); or
  - the following:
    - for professional Providers, make a payment based on publicly available Provider reimbursement data for the same or similar professional services, adjusted for geographical differences where applicable; or
    - for Hospital or facility Providers, make a payment based on publicly available data reflecting the approximate costs that Hospitals or facilities have incurred historically to provide the same or similar service, adjusted for geographical differences where applicable, plus a margin factor for the Hospital or facility.

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

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

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

- **Blue Cross Blue Shield Global Core**

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

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

  - **Inpatient Services**

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

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

— **Outpatient Services**

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

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

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

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

Determination of Benefits and Utilization Review

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

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

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

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

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

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

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

Covered Person/Provider Relationship

The choice of a Provider is solely yours.

Providers are not employees, agents or other legal representatives of the Plan or Claims Administrator.

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

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

Identity Theft Protection Services

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

Coordination of Benefits

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

- **Definitions**

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

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

  — Group, group-type, non-group, individual, blanket or franchise insurance coverage;

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

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

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

  — Group or individual automobile insurance coverage; and

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

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

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

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

- **Effect On Benefits**

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

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

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

- **Order of Benefit Determination**

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

  — When a Dependent child is covered under two group contracts, the contract covering the child as a Dependent of the parent whose birthday falls earlier in the Calendar Year pays first. (If one contract does not follow the "birthday rule" provision, then the rule followed by that contract is used to determine the order of benefits.)

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

  ◦ If the parent with custody of the child has not remarried, the coverage of the parent with custody pays first;

  ◦ When a divorced parent with custody has remarried, the coverage of the parent with custody pays first and the stepparent's coverage pays second before the coverage of the parent who does not have custody.

  ◦ Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses, the coverage of that parent pays first.

  ◦ When none of the above circumstances applies, the coverage you have had for the longest time pays first, except that a contract which covers you as a laid-off or retired employee or as a Dependent of such person pays after a contract which covers you as other than a laid-off or retired employee or Dependent of such person.

  — When the Claims Administrator requests information from another carrier to determine the extent or order of your benefits under an Other Contract, and such information is not furnished after a reasonable time, then the Claims Administrator shall:

  ◦ Assume the Other Contract is required to determine its benefits first;

  ◦ Assume the benefits of the Other Contract are identical to the Benefits of this coverage and pay its Benefits accordingly.

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

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

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

- **Facility of Payment**

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

- **Right of Recovery**

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

PLAN'S RIGHT OF RECOUPMENT

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

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

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

  If no refund is received, the Plan has the right to deduct any refund for any Overpayment due, up to an amount equal to the Overpayment, from:

  — any future Benefit payment made to any person or entity under this benefit booklet, whether for the same or a different Covered Person; or

  — any future benefit payment made to any person or entity under another self-funded benefit program administered by the Plan; or

  — any future benefit payment made to any person or entity under another group benefit plan or individual policy insured by the Plan; or

  — any future benefit payment, or other payment, made to any person or entity; or

  — any future payment owed to one or more Participating Providers or Out-of-Network Providers.

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

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

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

Limitations on Plan's Right of Recoupment/Recovery

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

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

Claims Administrator's Separate Financial Arrangements with Pharmacy Benefit Managers

The Claims Administrator owns a significant portion of the equity of Prime Therapeutics LLC and informs you that the Claims Administrator has entered into one or more agreements with Prime Therapeutics LLC or other entities (collectively referred to as "Pharmacy Benefit Managers") to provide, on the Claims Administrator's behalf, claim payments and certain administrative services for your Prescription Drug Benefits. Pharmacy Benefit Managers have agreements with pharmaceutical manufacturers to receive rebates for using their products. The Pharmacy Benefit Manager may share a portion of those rebates with the Claims Administrator. Neither the Employer nor you are entitled to receive any portion of such rebates as they are figured into the pricing of the product.

Claims Filing Procedures

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

Participating Providers

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

REMEMBER . . .

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

Prescription Drug Claims

To be eligible for maximum Benefits 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 amount due will be sent directly to you, after the Claims Administrator subtracts any Deductible and/or Coinsurance amounts which apply to your coverage.

Hospital Claims

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

Ambulatory Surgical Facility and Other Facility Claims

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

Physician and Other Provider Claims

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

EMPLOYEE-FILED CLAIMS

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

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

For health claims, you may send the completed form to:

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

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

Prime Therapeutics
P.O. Box 25136
Lehigh Valley, PA 18002-5136

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

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

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

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

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

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

Remember, the Claims Administrator must receive your claims for Covered Services within 12 months following the date of service for which the claim is made.

BENEFIT DETERMINATIONS FOR PROPERLY FILED CLAIMS

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

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

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

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

DIRECT CLAIMS LINE

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

Complaint/Appeal Procedure

The Claims Administrator has established the following process to review your dissatisfactions, complaints and/or appeals. If you have designated an authorized representative, that person may act on your behalf in the appeal process*.

If you have a question or complaint, an initial attempt should be made to resolve the problem by directly communicating with a Blue Cross and Blue Shield of Oklahoma Customer Service Representative. 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 Preauthorization decision, you must request an appeal within 180 days from the date you received notice of the adverse Benefit determination or Preauthorization notice. A Provider can also appeal the adverse Benefit determination or Preauthorization 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 Covered Person, the Covered Person 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 Claims Administrator may request further information if necessary.

  — In the case of an appeal involving a non-urgent Preauthorization request, the Claims Administrator 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 Preauthorization request, the Claims Administrator 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 Preauthorization Request Involving Urgent Care, you may appeal by calling the Preauthorization number shown on your Identification Card.

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

— The Claims Administrator will respond to you no later than 72 hours after the appeal is received.

— The Claims Administrator'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.

VOLUNTARY RE-REVIEW PROCESS (LEVEL II)

If you are not satisfied with the decision concerning the appeal, you may elect to submit an adverse Benefit determination to the Claims Administrator for re-review. The Claims Administrator will provide you with information about the Claims Administrator's voluntary re-review process.

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 Covered Person, the Covered Person 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 Claims Administrator may request further information if necessary.

Please keep in mind that you are not obligated to pursue or exhaust a Level II review before bringing a civil action. If these review processes do not provide a satisfactory resolution to your claim for Benefits, legal remedies are available, including pursuing your claim in court.

Employee Retirement Income Security Act of 1974 (ERISA)

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

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

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

Definitions

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

ACTIVELY AT WORK

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

ALLOWABLE CHARGE

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

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

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

AMBULATORY SURGICAL FACILITY

A Provider with an organized staff of Physicians which:

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

Applied Behavior Analysis

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

Autism Spectrum Disorder

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

Benefit Period

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

Benefits

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

Blue Distinction Centers

A national designation awarded by Blue Cross and Blue Shield Plans to Hospitals and medical facilities that have demonstrated expertise in delivery of quality health care in transplants.

BlueCard Provider

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

Calendar Year

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

COBRA Continuation Coverage

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

Coinsurance

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

Covered Drug

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

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

As new drugs are approved by the Food and Drug Administration (FDA), such drugs, unless the intended use is specifically excluded under this benefit booklet, will be reviewed by the Plan and may be added to the applicable Drug List and be eligible for Benefits as outlined in the ***Schedule of Benefits for Outpatient Prescription Drugs and Related Services***.

Covered Person

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

Covered Service

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

Custodial Care

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

Deductible

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

Dependent

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

Diagnostic Service

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

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

Drug List

A list of preferred drugs that may be covered under the ***Outpatient Prescription Drugs and Related Services*** section of this benefit booklet. The Drug List is subject to periodic review and may be changed at any time by the Claims Administrator. A current list is available on the Claims Administrator's Web site at www.bcbsok.com. You may also contact a Customer Service Representative at the telephone number shown on the back of your Identification Card for more information.

Durable Medical Equipment

Equipment which meets the following criteria:

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

Effective Date

The date when your coverage begins.

ELIGIBLE PERSON

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

EMERGENCY CARE

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

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

EMPLOYEE

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

EMPLOYEE AND CHILDREN COVERAGE

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

EMPLOYEE ONLY COVERAGE (OR SINGLE COVERAGE)

Coverage under the Plan for the Employee only.

EMPLOYEE, SPOUSE AND CHILDREN COVERAGE (OR FAMILY COVERAGE)

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

EMPLOYEE AND SPOUSE ONLY COVERAGE

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

EMPLOYER

The Cummins Construction Company, Inc.

ENROLL

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

ENROLLMENT DATE

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

EXPERIMENTAL/INVESTIGATIONAL/UNPROVEN

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

- The drug, device, biological product or medical treatment or procedure cannot be lawfully marketed without approval of the appropriate governmental or regulatory agency and approval for marketing has not been given at the time the drug, device, biological product or medical treatment or procedure is furnished; or

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

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

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

FAMILY COVERAGE

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

GENERIC DRUG

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

GROUP

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

GROUP HEALTH PLAN

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

HEALTH MAINTENANCE ORGANIZATION (HMO)

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

HOME HEALTH CARE AGENCY

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

HOME HEALTH CARE SERVICES

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

HOSPICE

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

HOSPITAL

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

- Is licensed;

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

HOSPITAL ADMISSION

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

IDENTIFICATION CARD

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

INITIAL ENROLLMENT PERIOD

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

INPATIENT

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

INTENSIVE OUTPATIENT TREATMENT

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

LICENSED PRACTICAL OR VOCATIONAL NURSE (LPN OR LVN)

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

Maternity Services

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

Medical Care

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

Medically Necessary (or Medical Necessity)

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

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

Medicare

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

Mental Illness

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

Network Provider

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

Non-Preferred Brand Drug

A brand-name Prescription Drug which does not appear on the Basic Drug List.

Open Enrollment Period

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

Orthognathic Surgery

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

Out-of-Network Pharmacy

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

Out-of-Network Provider

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

Out-of-Pocket Limit

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

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

Outpatient

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

Participating Pharmacy

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

To find a Pharmacy in the Participating Pharmacy Network, please refer to the Claims Administrator's Web site at www.bcbsok.com or call a Customer Service Representative at the number shown on your Identification Card.

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.

Placement for Adoption (or Placed for Adoption)

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

Plan

The Cummins Construction Company, Inc. Group Health Plan.

Preauthorization

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

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

Preferred Brand Drug

A brand–name Prescription Drug which appears on the Basic Drug List.

Preferred Participating Pharmacy

A Participating Pharmacy which has a written Agreement with the Claims Administrator to provide pharmaceutical services to Covered Persons or an entity chosen by the Claims Administrator to administer its prescription drug program that has been designated as a "Preferred Participating Pharmacy".

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

Prescription Drug

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

Prescription Order

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

Properly Filed Claim

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

Provider

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

Psychiatric Hospital

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

Qualifying Event

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

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

Registered Nurse (RN)

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

Residential Treatment Center

A state licensed and/or state certified facility that provides a 24-hour level of residential care to patients with long-term or severe Mental Illnesses and/or substance abuse disorders. This care is medically monitored, with 24-hour Physician availability and 24-hour onsite nursing services. It does not include half-way houses, wilderness programs, supervised living, group homes, boarding houses or other facilities or programs that provide primarily a supportive environment and address long-term social needs.

Retail Health Clinic

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

Retail Pharmacy Vaccination Network

A network of Participating Pharmacies that have certified vaccination Pharmacists on staff who have contracted to administer vaccinations to Covered Persons.

Routine Nursery Care

Ordinary Hospital nursery care of the newborn Covered Person.

Skilled Nursing Facility

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

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

SPECIAL ENROLLMENT PERIOD

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

SPECIALIST

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

SURGERY

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

TEMPOROMANDIBULAR JOINT DYSFUNCTION/SYNDROME (TMJ)

The treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the Temporomandibular Joint.

THERAPY SERVICE

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

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

Notice

This Group Health Plan believes this plan 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 your plan 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.

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 your Employer or the Plan Administrator.

If your Group Health Plan is subject to the Employee Retirement Income Security Act (ERISA), you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans. For nonfederal governmental plans, inquiries may be directed to the U.S. Department of Health and Human Services at www.healthreform.gov.

BlueCross BlueShield
of Oklahoma