

# Your Health Care Benefits Program



For Employees of

City of Oklahoma City by and through the  
Oklahoma City Municipal Facility Authority (OCMFA)

Group # 019574

Blue Choice Plan — Group Indemnity Standard Health Plan

Effective January 1, 2015

Administered by:



**BlueCross BlueShield of Oklahoma**

---

## *Blue Choice Schedule of Benefits for Comprehensive Health Care Services*

---

This schedule shows the Deductibles, Copayments and/or Coinsurance amounts that apply to Covered Services described in the *Comprehensive Health Care Services* section of your benefit booklet. **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](http://www.bcbsok.com) or call a Customer Service Representative at the number shown on your Identification Card to find a Network Provider near you.

### **OFFICE VISIT COPAYMENT**

The following Copayments will apply:

\$15 for each visit to a Provider's office, Urgent Care facility or Retail Health Clinic.

\$15 for each visit to a Provider's office for Psychiatric Care Services.

NOTE: For Covered Maternity Services, Copayment applies to initial prenatal visit only (per pregnancy).

The Copayment applies to charges which are billed as part of the office visit, except for:

- Preventive Care Services;
- Surgical services;
- Covered childhood immunizations.
- Physical Therapy, Occupational Therapy and Speech Therapy;
- Chemotherapy;
- Allergy testing and allergy injections;
- Durable Medical Equipment.

**Copayments do not apply to services received from Out-of-Network Providers.**

The Copayment will also apply to laboratory and x-ray services performed in conjunction with a covered office visit, except for magnetic resonance imaging (MRI), computed tomography (CT), positron emission tomography (PET), myocardial perfusion studies (MPS), and other similar imaging tests.

Hospital Admission Copayment	\$50 for each visit to a Hospital. This Copayment applies to all covered Services incurred during the Covered Person's admission to a hospital, except Routine Nursery Care.
Emergency Room Copayment	\$50 for each visit to a Hospital emergency room. This Copayment is waived if the Covered Person is admitted to the Hospital through the emergency room visit.
Outpatient Surgery Copayment	\$50 for each visit to an Outpatient facility for Surgery. This Copayment applies to surgical procedures received in a Hospital Outpatient department or Ambulatory Surgical Facility.
Free Standing Birthing Center Copayment	\$50 for each visit to a Free Standing Birthing Center. This Copayment applies to surgical procedures received in a Free Standing Birthing Center.
Skilled Nursing Facility	\$50 for each visit to a Skilled Nursing Facility. This Copayment applies to procedures received in a Skilled Nursing Facility.
Rehabilitation	\$50 for each visit for Rehabilitation. This Copayment applies to procedures received for Rehabilitation.

## DEDUCTIBLES

Benefit Period Deductible	<p><b>Network Provider Services</b> — \$250 per Benefit Period per Covered Person, or \$500 for all covered family members combined.</p> <p><b>Out-of-Network Provider Services</b> — \$300 per Benefit Period per Covered Person, or \$900 for all covered family members combined.</p> <p>Deductible amounts for Network Provider Services and Out-of-Network Provider Services <i>do not</i> cross-apply.</p>
Common Accident Provision	<p>If two or more Covered Persons incur expenses for Covered Services as a result of injuries received in the same accident, only one Deductible will be applied to the aggregate of such charges.</p>

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

- Routine Nursery Care.
- Covered Services received from an EMSA Ambulance Provider.
- Preventive Care Services.

## OUT-OF-POCKET LIMIT

- **Network Provider Services** — \$1,250 per Covered Person, or \$1,500 for all covered family members combined. When this limit has been paid (including any Copayment and/or Deductible amounts) for Covered Services provided by Network Providers during a Benefit Period, the amount of the Allowable Charges covered by the Plan for such Covered Person(s) will increase to 100% during the remainder of the Benefit Period for Covered Services received from Network Providers.

- **Out-of-Network Provider Services** —\$3,000 per Covered Person. When this limit has been paid (including any Copayment and/or Deductible amounts) for Covered Services provided by Out-of-Network Providers during a Benefit Period, the amount of Allowable Charges covered by the Plan for such Covered Person(s) will increase to 100% during the remainder of the Benefit Period for Covered Services received from Out-of-Network Providers.

Out-of-Pocket Limits for Network Provider Services and Out-of-Network Provider Services **do not** cross-apply.

The Out-of-Pocket Limit does not include any of the following:

- 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 Claims Administrator's requirements for Preauthorization, as set forth elsewhere in this benefit booklet.
- Charges in excess of the Allowable Charge.

## **BENEFIT PERCENTAGE**

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 Deductibles and/or Copayment amounts have been satisfied.

<b>COVERED SERVICES</b> (Subject to the <i>Comprehensive Health Care Services</i> section which follows)	<b>BENEFIT PERCENTAGE OF ALLOWABLE CHARGES COVERED BY THE PLAN</b>	
	<b><u>Network Provider Services</u></b>	<b><u>Out-of-Network Provider Services</u></b>
<b>PREVENTIVE CARE SERVICES</b>	100%	100%
<b>EMERGENCY CARE SERVICES</b>	90%	90%*

---

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

---

**HOSPITAL SERVICES\*\***

Preadmission Testing	90%	70%
All Other Covered Hospital Services	90%	70%

**SURGICAL/MEDICAL SERVICES**

Physician's Office Visit/Retail Health Clinic Visit	90%	70%
All Other Covered Surgical/Medical Services	90%	70%

**OUTPATIENT DIAGNOSTIC SERVICES**

90% 70%

**OUTPATIENT THERAPY SERVICES**

90% 70%

**MATERNITY SERVICES\*\*\***

Services received at a Freestanding Birthing Center	90%	70%
All Other Covered Maternity Services	90%	70%

**MASTECTOMY AND RECONSTRUCTIVE SURGICAL SERVICES**

90% 70%

**AMBULATORY SURGICAL FACILITY SERVICES**

90% 70%

**SERVICES RELATED TO TREATMENT OF AUTISM AND AUTISM SPECTRUM DISORDERS**

90% 70%

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

\*\* Inpatient Hospital Services are subject to Preauthorization approval from the Claims Administrator. See the **Important Information** section for details regarding "Preauthorization" requirements.

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

<b>COVERED SERVICES</b> (Subject to the <i>Comprehensive Health Care Services</i> section which follows)	<b>BENEFIT PERCENTAGE OF ALLOWABLE CHARGES COVERED BY THE PLAN</b>	
	<b><u>Network Provider Services</u></b>	<b><u>Out-of-Network Provider Services</u></b>
<b>HUMAN ORGAN, TISSUE AND BONE MARROW TRANSPLANT SERVICES*</b>	90%	70%
<b>PSYCHIATRIC CARE SERVICES</b> (Copayment applies)	90%	70%
<b>AMBULANCE SERVICES</b>	90%	70%
<b>PRIVATE DUTY NURSING SERVICES</b>	90%	70%
<b>REHABILITATION CARE*</b>	90%	70%
<b>SKILLED NURSING FACILITY SERVICES*</b> 120-day maximum per Benefit Period	90%	70%
<b>HOME HEALTH CARE SERVICES*</b> 120-visit maximum per Benefit Period	90%	70%
<b>HOSPICE SERVICES*</b>	90%	70%
<b>TEMPOROMANDIBULAR JOINT SYNDROME/DYSFUNCTION</b>	90%	70%
<b>DENTAL SERVICES FOR ACCIDENTAL INJURY</b>	90%	70%
<b>DIABETES EQUIPMENT, SUPPLIES AND SELF-MANAGEMENT SERVICES</b>	90%	70%
<b>SERVICES RELATED TO CLINICAL TRIALS</b>	90%	70%
<b>DURABLE MEDICAL EQUIPMENT</b>	90%	70%
<b>PROSTHETIC APPLIANCES</b>	90%	70%
<b>ORTHOTIC DEVICES</b>	90%	70%
<b>WIGS OR OTHER SCALP PROSTHESES</b>	90%	70%
<b>CHIROPRACTIC MEDICAL SERVICES</b> (Copayment applies)	90%	70%

\*Subject to Preauthorization approval from the Claims Administrator. See the **Important Information** section for details regarding "Preauthorization" requirements.

<b>COVERED SERVICES</b> (Subject to the <i>Comprehensive Health Care Services</i> section which follows)	<b>BENEFIT PERCENTAGE OF ALLOWABLE CHARGES COVERED BY THE PLAN</b>	
	<b><u>Network Provider Services</u></b>	<b><u>Out-of-Network Provider Services</u></b>
<b>MUSCLE MANIPULATIONS</b> Maximum of 30 visits to a Chiropractor per Benefit Period	90%	70%
<b>WEIGHT LOSS AND WEIGHT LOSS SURGERY</b> Limited to treatment of obesity and morbid obesity.	90%	70%
<b>ALL OTHER COVERED SERVICES</b>	90%	70%

# Table of Contents

<b>Blue Choice Schedule of Benefits for Comprehensive Health Care Services</b> .....	<b><i>i</i></b>
<b>Plan Summary</b> .....	<b><i>1</i></b>
<b>Important Information</b> .....	<b><i>2</i></b>
Your Participating Provider Network .....	<i>2</i>
How Your Coverage Works .....	<i>2</i>
Cost Sharing Features of Your Coverage .....	<i>2</i>
Selecting a Provider .....	<i>2</i>
The BlueCard® Program .....	<i>3</i>
Medically Necessary or Medical Necessity Limitation .....	<i>3</i>
Preauthorization .....	<i>4</i>
Concurrent Review .....	<i>6</i>
What To Do In An Emergency .....	<i>6</i>
Allowable Charge .....	<i>7</i>
Special Notices .....	<i>8</i>
Identification Card .....	<i>8</i>
Designating an Authorized Representative .....	<i>9</i>
Questions .....	<i>9</i>
<b>Eligibility, Enrollment, Changes &amp; Termination</b> .....	<b><i>10</i></b>
Who Is an Eligible Person .....	<i>10</i>
Who Is an Eligible Dependent .....	<i>10</i>
Changing from Individual to Family Coverage or Adding Dependents to Family Coverage .....	<i>11</i>
When Coverage Begins .....	<i>12</i>
Late Applicants .....	<i>12</i>
Medicare Eligible Covered Persons .....	<i>12</i>
Your MSP Responsibilities .....	<i>13</i>
How to Enroll .....	<i>13</i>
Initial Enrollment Period .....	<i>13</i>
Special Enrollment Periods .....	<i>14</i>
Open Enrollment Period .....	<i>16</i>
Qualified Court Orders for Medical Coverage for Dependent Children .....	<i>16</i>
Delayed Effective Date .....	<i>17</i>
Deleting a Dependent .....	<i>17</i>
COBRA Continuation Coverage .....	<i>17</i>
When Coverage Under This Plan Ends .....	<i>18</i>
<b>Comprehensive Health Care Services</b> .....	<b><i>20</i></b>
Preventive Care Services .....	<i>20</i>
Emergency Care Services .....	<i>22</i>
Hospital Services .....	<i>22</i>
Surgical/Medical Services .....	<i>23</i>
Outpatient Diagnostic Services .....	<i>25</i>
Outpatient Therapy Services .....	<i>26</i>
Maternity Services .....	<i>26</i>
Mastectomy and Reconstructive Surgical Services .....	<i>28</i>
Human Organ, Tissue and Bone Marrow Transplant Services .....	<i>28</i>
Ambulatory Surgical Facility Services .....	<i>31</i>
Services Related to Treatment of Autism and Autism Spectrum Disorders .....	<i>31</i>
Psychiatric Care Services .....	<i>32</i>
Ambulance Services .....	<i>32</i>
Private Duty Nursing Services .....	<i>33</i>
Rehabilitation Care .....	<i>33</i>



Skilled Nursing Facility Services .....	33
Home Health Care Services .....	33
Hospice Services .....	34
Dental Services for Accidental Injury .....	34
Diabetes Equipment, Supplies and Self-Management Services .....	34
Services Related to Clinical Trials .....	36
Durable Medical Equipment .....	36
Prosthetic Appliances .....	37
Orthotic Devices .....	37
Wigs or Other Scalp Protheses .....	38
Christian Science Services .....	38
<b>Exclusions .....</b>	<b>39</b>
What Is Not Covered .....	39
<b>General Provisions .....</b>	<b>43</b>
Benefits to Which You Are Entitled .....	43
Prior Approval .....	43
Notice and Properly Filed Claim .....	43
Limitation of Actions .....	43
Payment of Benefits .....	43
Benefits for Services Outside the State of Oklahoma .....	44
Determination of Benefits and Utilization Review .....	44
Covered Person/Provider Relationship .....	45
Coordination of Benefits .....	45
Plan's Right of Recoupment .....	47
Limitations on Plan's Right of Recoupment/Recovery .....	48
<b>Claims Filing Procedures .....</b>	<b>49</b>
Participating Providers .....	49
Hospital Claims .....	49
Ambulatory Surgical Facility and Other Facility Claims .....	49
Physician and Other Provider Claims .....	49
Employee-Filed Claims .....	49
Benefit Determinations for Properly Filed Claims .....	50
Direct Claims Line .....	50
<b>Complaint/Appeal Procedure .....</b>	<b>51</b>
If a Claim Is Denied or Not Paid in Full .....	51
Timing of Required Notices and Extensions .....	52
Claim Appeal Procedures .....	53
Standard External Review .....	56
Expedited External Review .....	58
Exhaustion .....	59
Interpretation of Employer's Plan Provisions .....	59
<b>Definitions .....</b>	<b>61</b>

---

## *Plan Summary*

---

City of Oklahoma City (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, 2015, 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.

The 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* Deductibles and/or Coinsurance amounts and Out-of-Pocket Limit 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.**

### **COST SHARING FEATURES OF YOUR COVERAGE**

As a participant in this Group Health Plan, you have the responsibility for sharing in a portion of your health care costs. You are responsible for the applicable Deductible, Copayment and/or Coinsurance provisions of your coverage, as well as any charges for which Benefits are not provided. You may also be responsible for a portion of your health care contributions, depending upon the terms of your Group Health Plan. Check with your Group Administrator for specific contribution 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](http://www.bcbsok.com). You may also call a Customer Service Representative for assistance in locating a Network Provider. Simply call the toll-free number shown on your Identification Card.

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

## **THE BLUECARD® PROGRAM**

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

- **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're outside the state of Oklahoma and need health care.

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

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

### **HOW THE BLUECARD 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're only responsible for meeting your Deductibles, Copayment and/or Coinsurance payments, if any.
- ✓ All participating Physicians and Hospitals are paid directly.

## **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 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 related to treatment of Mental Illness (including severe 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 working 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.

Preauthorization is not required for therapy visits to a Physician or other professional Provider licensed to perform Covered Services under this Group Health Plan.

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

- **Response to Preauthorization Requests for Inpatient Services**

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

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

If an extension of time is necessary due to the Claims Administrator need for additional information, you will be notified 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 Inpatient Services for Urgent Care**

A “*Preauthorization Request Involving Inpatient Services for 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 Inpatient Services for 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 by the Claims Administrator that the services were Medically Necessary. If it is determined that the services were not Medically Necessary or were Experimental, Investigational and/or Unproven, it may be the Covered Person’s responsibility to pay the full cost of the services received.

If the Covered Person fails to obtain 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 and/or Unproven, Benefits will be reduced or denied.

**Please keep in mind that any treatment you receive which is not a Covered Service under this Plan, or is not determined to be Medically Necessary, will be excluded from your Benefits. 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 these Providers offers you the following advantages:

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

### **REMEMBER ...**

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

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

- **The Allowable Charge for Non-Contracting Providers for Covered Services will be the lesser of:**
  - the Provider’s billed charges; or
  - the Claims Administrator’s Non-Contracting Allowable Charge.

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

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



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

- Notwithstanding anything in the Group Health Plan to the contrary, for Out-of-Network Emergency Care Services rendered by Non-Contracting Providers, the Allowable Charge shall be equal to the greatest of the following three possible amounts – not to exceed billed charges:
  - the median amount negotiated with network or contracting Providers for the Emergency Care Services furnished;
  - the amount for the Emergency Care Services calculated using the same method the 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
  - the amount that would be paid under Medicare for the Emergency Care Services.

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

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

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

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

## **SPECIAL NOTICES**

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

Because of changes in federal or state laws, 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 a “special notice”. 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 covered 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 Inpatient Services for 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 booklet. 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:

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**

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

- Meet the following definition of an Eligible Person: A regular, full-time active Employee of the Employer;
- An employee on disability leave due to an on-the-job injury on regular, full-time employment on the date the disabling injury or illness occurred;
- A retired employee who qualifies under Chapter 40 of the Oklahoma City code, 1997 amended;
- An elected official of the The City of Oklahoma City;
- A regular, full-time active employee of an approved participating municipal trust;
- A COBRA participant;
- A surviving spouse or surviving minor of a deceased eligible employee or retiree, but not including new spouses or Dependents of the survivor;
- 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.

Your Effective Date is the first of the month following one full month of employment (excluding month of hire).

### **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 his/her spouse is also considered a Dependent child under the Plan, provided proof of dependency is provided to the Plan, as appropriate.

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.

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

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.

### **CHANGING FROM INDIVIDUAL TO FAMILY COVERAGE OR ADDING DEPENDENTS TO FAMILY COVERAGE**

You can change from Individual to Family Coverage or add Dependents to your Family Coverage because of any of the following events:

- Marriage.
- Establishment of a Common Law Marriage.
- Birth, adoption or Placement for Adoption of a child.
- Obtaining legal guardianship of a child.
- Loss of eligibility for other health coverage for you or your Dependent if:
  - The other coverage was in effect when you were first eligible to Enroll for this coverage;
  - The other coverage is not terminating for cause (such as failure to pay premiums or making a fraudulent claim); and
  - Where required, you stated in writing that coverage under another Group Health Plan or other health insurance coverage was the reason for declining enrollment in this coverage.

This includes, but is not limited to, loss of coverage due to:

- Legal separation, divorce, cessation of Dependent status, death, termination of employment, or reduction in the number of hours of employment;
  - In the case of HMO coverage, moving out of the HMO service area;
  - Reaching a lifetime limit on all benefits in another Group Health Plan; or
  - Another Group Health Plan no longer offering any benefits to the class of similarly situated individuals that includes you or your Dependent.
- Termination of employer contributions towards your or your Dependent's other coverage.
  - Exhaustion of COBRA Continuation Coverage or state continuation coverage.

## **WHEN COVERAGE BEGINS**

Your Family Coverage or the coverage for your additional Dependents will be effective from the date of the event if you apply for this change within 31 days of any of the following events:

- Marriage.
- Establishment of a Common Law Marriage.
- Birth, adoption, or Placement of Adoption of a child.
- Obtaining legal guardianship of a child.

NOTE: Coverage for a newborn will be effective on the date of birth and continue for 31 days. In order to extend the coverage beyond 31 days, you must notify your Employer so that your membership records can be adjusted. You must notify your Employer within 31 days even if the addition of a newborn to existing Family Coverage extends beyond 31 days and does not result in an additional premium.

Your Family Coverage or the coverage for your additional Dependents will be effective from the date you apply for coverage if you apply within 31 days of any of the following events:

- Loss of eligibility for other coverage for you or your Dependent, except for loss of coverage due to reaching a lifetime limit on all benefits.
- Termination of employer contributions towards your or your Dependent's other coverage.
- Exhaustion of COBRA Continuation Coverage or state continuation coverage.

If coverage is lost in another Group Health Plan because a lifetime limit on all benefits is reached under that coverage and you apply for Family Coverage or to add Dependents within 31 days after a claim is denied due to reaching the lifetime limit, your Family Coverage or the coverage for your additional Dependents will be effective from the date your claim was denied.

## **LATE APPLICANTS**

If you do not apply for coverage or add Dependents to your coverage within 31 days of the event (or within 60 days in instances related to Medicaid or CHIP coverage), as described above, you may apply for coverage during the next Open Enrollment Period. An Open Enrollment Period will be held each year at a time designated by your Employer. Your application for coverage must be received by your employer within this time period. ~~Individuals who Enroll during an Open Enrollment Period will be considered Late Enrollees under the Plan and will be subject to the 365 days Preexisting Condition Waiting Period as described in the "Exclusions" section of this benefit booklet.~~

## **MEDICARE ELIGIBLE COVERED PERSONS**

If you meet the definition of an Eligible Person stated in this section above and you are eligible for Medicare and not affected by the "Medicare Secondary Payer" (MSP) laws as described below, the Benefits described in the section of this plan document entitled "Benefits for Medicare Eligible Covered Persons" will apply to you and to your spouse and covered Dependent children (if he or she is also eligible for Medicare and not affected by the MSP laws).

A series of federal laws collectively referred to as the "Medicare Secondary Payer" (MSP) laws regulate the manner in which certain employers may offer group health care coverage to Medicare eligible employees, spouses, and in some cases, Dependent children.

The statutory requirements and rules for MSP coverage vary depending on the basis for Medicare and employer Group Health Plan ("GHP") coverage, as well as certain other factors, including the size of the employers sponsoring the GHP. In general, Medicare pays secondary to the following:

- GHPs that cover individuals with end-stage renal disease (“ESRD”) during the first 30 months of Medicare eligibility or entitlement. This is the case regardless of the number of employees employed by the employer or whether the individual has “current employment status.”
- In the case of individuals age 65 or over, GHPs of employers that employ 20 or more employees if that individual or the individual’s spouse (of any age) has “current employment status.” If the GHP is a multi-employer or multiple employer plan, which has at least one participating employer that employs 20 or more employees, the MSP rules apply even with respect to employers of fewer than 20 employees (unless the plan elects the small employer exception under the statute).
- In the case of disabled individuals under age 65, GHPs of employers that employ 100 or more employees, if the individual or a member of the individual’s family has “current employee status.” If the GHP is a multi-employer or multiple employer plan, which has at least one participating employer that employs 100 or more employees, the MSP rules apply even with respect to employers of fewer than 100 employees.

**PLEASE NOTE: SEE YOUR EMPLOYER OR PLAN ADMINISTRATOR SHOULD YOU HAVE ANY QUESTIONS REGARDING THE ESRD PRIMARY PERIOD OR OTHER PROVISIONS OF MSP LAWS AND THEIR APPLICATION TO YOU, YOUR SPOUSE OR ANY DEPENDENTS.**

### **YOUR MSP RESPONSIBILITIES**

In order to assist your employer in complying with MSP laws, it is very important that you promptly and accurately complete any requests for information from the Claims Administrator and/or your employer regarding the Medicare eligibility of you, your spouse and covered Dependent children. In addition, if you, your spouse or covered Dependent child becomes eligible for Medicare, or has Medicare eligibility terminated or changed, please contact your employer or your Plan administrator promptly to ensure that your Claims are processed in accordance with applicable MSP laws.

### **HOW TO ENROLL**

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

### **INITIAL ENROLLMENT PERIOD**

- **Initial Group Enrollment**

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

**IMPORTANT:**

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

— **Adopted Children**

An adopted child or a child Placed for Adoption may be added to your coverage, provided your application is received by the Plan 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. A person who Enrolls during a Special Enrollment Period is not treated as a late enrollee.

• **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 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 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 the birth, adoption or Placement for Adoption.

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

An Eligible Dependent is not considered a late enrollee if the Employee’s application to add the Dependent is received within 31 days after issuance of a court order requiring coverage be provided for a spouse or minor or Dependent child under the 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, Copayment 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**

**THIS PROVISION MAY NOT APPLY TO YOUR PLAN'S COVERAGE. PLEASE CHECK WITH YOUR GROUP ADMINISTRATOR TO DETERMINE IF YOUR PLAN IS SUBJECT TO COBRA\* REGULATIONS.**

- **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:

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

- 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 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.

- **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.**

### **PREVENTIVE CARE SERVICES**

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

- Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (“USPSTF”);
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (“CDC”) with respect to the individual involved;
- Evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”) for infants, children, and adolescents; and
- With respect to women, such additional preventive care and screenings, not described above, as provided for in comprehensive guidelines supported by the HRSA. Such services will include the following:
  - Breast-feeding Support, Services and Supplies — Benefits will be provided for breast-feeding counseling and support services rendered by a Provider for pregnant and postpartum women. Benefits include the rental (or, at the Claims Administrator’s option, the purchase) of manual or electric breast-feeding equipment.
  - Contraceptive Services — Benefits will be provided for the following contraceptive services when prescribed by a licensed Provider for women with reproductive capacity:
    - contraceptive counseling;
    - FDA-approved prescription devices and medications;
    - over-the-counter contraceptives; and
    - sterilization procedures (tubal ligation), but not including hysterectomy.

Coverage includes contraceptives in the following categories:

- progestin-only contraceptives;
- combination contraceptives;
- emergency contraceptives;
- extended-cycle/continuous oral contraceptives;
- cervical caps;
- diaphragms;

- implantable contraceptives;
- intra-uterine devices;
- injectables;
- transdermal contraceptives; and
- vaginal contraceptive devices.

**NOTE:** Prescription contraceptive medications are covered under the *Outpatient Prescription Drugs and Related Services* section of this benefit booklet, *if applicable*.

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

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

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

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

The Preventive Care Services listed above may change as USPSTF, CDC and HRSA guidelines are modified. For more information, Covered Persons may access the Web site at [www.bcbsok.com](http://www.bcbsok.com) or contact Customer Service at the toll-free number listed on their Identification Card.

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

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

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

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

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

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

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

## **EMERGENCY CARE SERVICES**

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

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

Coverage for Emergency Care shall be provided in accordance with the terms and conditions of the appropriate Benefit section of this 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 30%, 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.

## **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

\*A procedure performed at the same time as a primary surgical procedure, but which is clinically integral to the performance of the primary procedure, and is not reimbursed separately.



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

— Sterilization, regardless of Medical Necessity.

— Weight Loss Surgery

— Oral Surgery

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

- **Assistant Surgeon**

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

- **Anesthesia**

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

- **Inpatient Medical Services**

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

— Inpatient Medical Care Visits

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

— Intensive Medical Care

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

— Concurrent Care

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

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

— Consultation

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

— Newborn Well Baby Care

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

- **Outpatient Medical Services**

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

— Emergency Accident Care

Treatment of accidental bodily injuries.

— Emergency Medical Care

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

— Home, Office and Other Outpatient Visits

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

— Contraceptive Devices

Contraceptive devices which are:

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

— Audiological Services

Audiological services and hearing aids, limited to:

- One hearing aid per ear every 48 months for Covered Persons up to age 19; and
- Up to four additional ear molds per Benefit Period for Covered Persons up to two years of age.

**Adult Audiometric examinations, hearing aid evaluations, conformity evaluations and hearing aids are limited to a Benefit maximum of \$500 every 24 months for Covered Persons age 19 and over.**

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

— Infertility

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.

— Muscle Manipulations

Spinal adjustment and manipulation, x-rays for manipulation and adjustment and other modalities performed by a D.O. (Doctor of Osteopathic).

**Services for muscle manipulations, when performed by a Chiropractor, are limited to the number of visits specified in *Schedule of Benefits for Comprehensive Health Care Services*.**

## **OUTPATIENT DIAGNOSTIC SERVICES**

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

## OUTPATIENT THERAPY SERVICES

- Radiation Therapy
- Chemotherapy

**Outpatient Therapy Services do not include oral Chemotherapy or self-injectable/self-administered Chemotherapy. These Prescription Drugs may be covered under your *Outpatient Prescription Drugs and Related Services*, if applicable.**

- Respiratory Therapy
- Dialysis Treatment
- Physical Therapy

Benefits for Outpatient Physical Therapy include visits to the Covered Person's home.

- Occupational Therapy

Benefits for Outpatient Occupational Therapy include visits to the Covered Person's home.

- Speech Therapy

Benefits for Outpatient Speech Therapy include visits to the Covered Person's home and are limited to services to restore speech to a Covered Person who has lost an existing speech function as a result of disease or injury.

## MATERNITY SERVICES

- "*Hospital Services*" and "*Surgical/Medical Services*" from a Provider (not 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.

- 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.
  - 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 covered.**

## MASTECTOMY AND RECONSTRUCTIVE SURGICAL SERVICES

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

- Inpatient Hospital Services for:
  - not less than 48 hours of Inpatient care following a mastectomy; and
  - not less than 24 hours of Inpatient care following a lymph node dissection for the treatment of breast cancer.However, coverage may be provided for a shorter length of Hospital Inpatient stay where the attending Physician, in consultation with the patient, determines that a shorter period of Hospital stay is appropriate.
- Coverage for reconstructive breast Surgery performed as a result of a partial or total mastectomy. Covered Services shall consist of the following, when provided in a manner determined in consultation with the attending Physician and the patient:
  - reconstruction of the breast on which the mastectomy has been performed;
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
  - prostheses and physical complications at all stages of mastectomy, including lymphedema.

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

## HUMAN ORGAN, TISSUE AND BONE MARROW TRANSPLANT SERVICES

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

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

- **Definitions**

In addition to the definitions listed under the *Definitions* section, 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 AND AUTISM SPECTRUM DISORDERS**

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

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



## PSYCHIATRIC CARE SERVICES

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

- Inpatient Facility Services

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

- Inpatient Medical Services

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

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

Electroshock treatment or convulsive drug therapy including anesthesia when 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

- Facility and Medical Services

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

- Day/Night Psychiatric Care Services

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

- Drug Addiction, Substance Abuse and Alcoholism

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

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

### **REHABILITATION CARE**

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

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

**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 30% 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 30% 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 30% reduction in Benefits for Home Health Care 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;
- Speech therapy;
- Durable Medical Equipment;
- Food or home-delivered meals;
- Intravenous drug, fluid or nutritional therapy, **except when you have received Preauthorization from the Claims Administrator for these services.**

## **HOSPICE SERVICES**

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

**Hospice Services are subject to the “Preauthorization” requirements of the Plan (see *Important Information section*). Failure to comply with these requirements will result in a 30% reduction in Benefits for Hospice Services, if, upon receipt of a claim, Benefits are available under the Plan.**

## **DENTAL SERVICES FOR ACCIDENTAL INJURY**

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

## **DIABETES EQUIPMENT, SUPPLIES AND SELF-MANAGEMENT SERVICES**

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

- Blood glucose monitors;
  - Blood glucose monitors to the legally blind;
  - Test strips for glucose monitors;
  - Visual reading and urine testing strips;
  - Insulin;
  - Injection aids;
  - Cartridges for the legally blind;
  - Syringes;
  - Insulin pumps and appurtenances thereto;
  - Insulin infusion devices;
  - Oral agents for controlling blood sugar;
  - Podiatric appliances for prevention of complications associated with diabetes; and
  - Other diabetes equipment and related services that are determined Medically Necessary by the Oklahoma State Board of Health, provided such equipment and supplies have been approved by the federal Food and Drug Administration (FDA).
- Diabetes self-management training in an Inpatient or Outpatient setting which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalizations and complications. Diabetes self-management training must be conducted in accordance with the standards developed by the Oklahoma State Board of Health in consultation with a national diabetes association affiliated with this state and at least three medical directors of health benefit plans selected by the Oklahoma State Department of Health. Coverage for diabetes self-management training, including medical nutrition therapy relating to diet, caloric intake and diabetes management (excluding programs of which the only purpose are weight reduction) shall be limited to the following:
    - Visits Medically Necessary upon the diagnosis of diabetes;
    - A Physician diagnosis which represents a significant change in the patient's symptoms or condition making Medically Necessary changes in the patient's self-management; and
    - Visits when reeducation or refresher training is Medically Necessary.

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

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

## **SERVICES RELATED TO CLINICAL TRIALS**

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

- Any of the following federally funded or approved trials:
  - The Centers for Disease Control and Prevention of the United States Department of Health and Human Services;
  - The National Institutes of Health (NIH);
  - The Centers for Medicare and Medicaid Services;
  - The Agency for Healthcare Research and Quality;
  - A cooperative group or center of any of the previous entities;
  - The United States Food and Drug Administration;
  - The United States Department of Defense (DOD);
  - The United States Department of Veterans Affairs (VA);
  - A qualified non-governmental research entity identified in guidelines issued by the NIH for center support grants or the DOD, VA or Department of Energy if the study has been reviewed and approved through a peer review system; or
  - An institutional review board of an institution in this state that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services.
- A clinical trial conducted under an FDA investigational new drug application.
- A drug trial that is exempt from the requirement of an FDA investigational new drug application.

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

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

- The cost of the investigational item, device or service;
- The cost of items and services provided solely to satisfy data collection and analysis needs and that are not used in direct clinical management;
- The cost for a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
- The cost for a clinical trial that does not meet criteria established by applicable law.

## **DURABLE MEDICAL EQUIPMENT**

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

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

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

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

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

### **PROSTHETIC APPLIANCES**

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

**Benefits for replacement appliances will be provided only when 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.

Not covered are:

- Arch supports and other foot support devices;

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

#### **WIGS OR OTHER SCALP PROSTHESES**

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

#### **CHRISTIAN SCIENCE SERVICES**

Spiritual treatment of an illness or injury when rendered by a qualified Christian Science Practitioner (one who is listed in the Christian Science Journal at the time services are rendered) or an accredited Christian Science Sanitorium (one that is certified by the Mother Church in Boston at the time services are rendered).

---

## *Exclusions*

---

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

### **WHAT IS NOT COVERED**

Except as otherwise specifically stated in this benefit booklet, we do not provide Benefits for services, supplies or charges:

- Which are not prescribed by or performed by or upon the direction of a Physician or other Provider.
- Which 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 would have been made if you had applied for Medicare and claimed Medicare benefits, or to the extent governmental units provide benefits (some state or federal laws may affect how we apply this exclusion).
- For any illness or injury suffered after the Covered Person's Effective Date as a result of war or any act of war, declared or undeclared, when serving in the military or any auxiliary unit thereto.
- For which you have no legal obligation to pay in the absence of this or like coverage.
- Received from a dental or medical department maintained by or on behalf of an Employer, mutual benefit association, labor union, trust, or similar person or group.



- Any services and supplies 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; 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.

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 treating practitioner, 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 eye Surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).
- For transsexual Surgery or any treatment leading to or in connection with transsexual Surgery.
- For treatment or medications for infertility and fertilization procedures. Examples include any form of: artificial insemination; ovulation induction procedures; in vitro fertilization; embryo transfer; or any other procedures, supplies or medications which in any way are intended to augment or enhance your reproductive ability.
- For treatment of sexual problems not caused by organic disease.
- For smoking cessation programs (not including counseling or medications as specified under “*Preventive Care Services*”).
- For drugs and medicines purchased by a Covered Person on an Outpatient basis, with or without a Physician’s prescription, including drugs and medicines dispensed in the Physician’s office, in the Outpatient department of a Hospital, or other Outpatient setting.
- For 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 and Autism Spectrum Disorders*”.
- For or related to applied behavior analysis.
- For hippotherapy, equine assisted learning or other therapeutic riding programs.
- For which the Provider of service customarily makes no direct charge to a Covered Person.

- 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 abortion, unless the life of the mother is endangered.
- For transcutaneous electrical nerve stimulator (TENS).
- For Inpatient drug and alcohol treatment that is not rendered in a Hospital, Psychiatric Hospital, Residential Treatment Center or other Plan-approved Provider.
- For massage therapy, including but not limited to effleurage, petrissage and/or tapotement.
- 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 they have allowed for Benefits under the Plan. You must provide to the Plan 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 after the end of the Benefit Period for which claim is made.

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

### **LIMITATION OF ACTIONS**

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

### **PAYMENT OF BENEFITS**

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

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

Once a Provider 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 will accept the Allowable Charge as payment in full, less any Deductible, Copayment and/or Coinsurance, and will make no additional charge to you for Covered Services. **However, if you receive Covered Services from an Out-of-Network Provider, you may be responsible for amounts which exceed the Allowable Charge, in addition to any Deductible, Copayment and/or Coinsurance amounts which may apply.**

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

### **BENEFITS FOR SERVICES OUTSIDE THE STATE OF OKLAHOMA**

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

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

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

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

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

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

### **DETERMINATION OF BENEFITS AND UTILIZATION REVIEW**

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

In determining whether services or supplies are Covered Services, the Claims Administrator will determine whether a service or supply is Medically Necessary or if such service or supply is Experimental, Investigation 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](http://www.bcbsok.com).

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

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

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

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

#### **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 trustee plans, union welfare plans, employer organization plans or employee benefit organization plans;
- Coverage toward the cost of which any employer has contributed, or with respect to which any employer has made payroll deduction;
- 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, we will pay Benefits for Covered Services without regard to your coverage under any Other Contract.

**When the Plan is secondary, the Benefits we pay for Covered Services 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 earliest in the Calendar Year pays first. (If one contract does not follow the “birthday rule” provision, then the rule followed by that contract is used to determine the order of benefits.)

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

- If the parent with custody of the child has not remarried, the coverage of the parent with custody pays first.
- When a divorced parent with custody has remarried, the coverage of the parent with custody pays first and the stepparent’s coverage pays second before the coverage of the parent who does not have custody.
- Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child’s health care expenses, the coverage of that parent pays first.
- When none of the above circumstances applies, the coverage you have had for the longest time pays first, except that a contract which covers you as a laid–off or retired employee or as a Dependent of such person pays after a contract which covers you as other than a laid–off or retired employee or Dependent of such person.

- When the Claims Administrator requests information from another carrier to determine the extent or order of your benefits under an Other Contract, and such information is not furnished after a reasonable time, then the Claims Administrator shall:
  - Assume the Other Contract is required to determine its benefits first;
  - Assume the benefits of the Other Contract are identical to the Benefits of this coverage and pay its Benefits accordingly.

Once the Claims Administrator receives the necessary information to determine your benefits under the Other Contract and to establish the order of benefit determination under the rules listed above, prior payments under this 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 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 we pay more for Covered Services than this provision requires, then the Plan has the right to recover the excess from anyone to or for whom the payment was made. You agree to do whatever is necessary to secure the Plan's right to recover the excess payment.

## **PLAN'S RIGHT OF RECOUPMENT**

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

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

---

The Plan begins to pay only after any applicable Deductible and/or Copayment amount you incur toward eligible expenses shows on the Claims Administrator's records. When your Physician, Hospital or other Provider of health care services submits bills for you, your Deductible and/or Copayment 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 Copayment. Then the Claims Administrator's records will show that you have incurred the Deductible and/or Copayment 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 must use an Out-of-Network Provider who does not file for you, you should follow the guidelines below in submitting your claims.

#### **REMEMBER . . .**

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

### **HOSPITAL CLAIMS**

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

### **AMBULATORY SURGICAL FACILITY AND OTHER FACILITY CLAIMS**

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

### **PHYSICIAN AND OTHER PROVIDER CLAIMS**

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

### **EMPLOYEE-FILED CLAIMS**

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

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

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

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

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

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

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

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

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

**Remember, the Claims Administrator must receive your claims for Covered Services within 12 months after the end of the Benefit Period for which claim is made.**

#### **BENEFIT DETERMINATIONS FOR PROPERLY FILED CLAIMS**

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

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

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

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

#### **DIRECT CLAIMS LINE**

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

---

## *Complaint/Appeal Procedure*

---

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

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

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

### **IF A CLAIM IS DENIED OR NOT PAID IN FULL**

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

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

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

- In the case of a denial of an Urgent Care Claim, a description of the expedited review procedure applicable to such claims. An Urgent Care Claim decision may be provided orally, so long as a written notice is furnished to the claimant within three days of oral notification; and
- Contact information for applicable office of health insurance consumer assistance or ombudsman.

**TIMING OF REQUIRED NOTICES AND EXTENSIONS**

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

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

**URGENT CARE CLAIMS\***

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

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

## PRE-SERVICE CLAIMS

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

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

## POST-SERVICE CLAIMS

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

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

## CLAIM APPEAL PROCEDURES

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

An “**Adverse Benefit Determination**” means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Benefit, including any such denial, reduction, termination, or failure to provide or make payment for, a Benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which Benefits are otherwise provided because it is determined to be Experimental, Investigational and/or Unproven or not Medically Necessary or appropriate. If an ongoing course of treatment had been approved by the Claims Administrator or your Employer and the Claims Administrator or your Employer reduces or terminates such treatment (other than by amendment or termination

of the Employer’s Benefit Plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination. A rescission of coverage is also an Adverse Benefit Determination. It does not include a termination of coverage for reasons related to non-payment of premium.

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

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

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

Upon receipt of an expedited pre-service or concurrent clinical appeal, the Claims Administrator will notify the party filing the appeal, as soon as possible, but no more than 24 hours after submission of the appeal, of all the information needed to review the appeal. Additional information must be submitted within 24 hours of request. The Claims Administrator shall render a determination on the appeal as soon as possible (taking into account medical exigencies), but no later than 72 hours after it receives the initial request, or within 48 hours after it receives the missing information (if the initial request is incomplete).

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

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

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

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

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

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

- The Claims Administrator will honor telephone requests for information. However, such inquiries will not constitute a request for review.
- In support of your claim review, you have the option of presenting evidence and testimony to the Claims Administrator by phone or in person at a location of the Claims Administrator’s choice. You and your authorized representative may ask to review your file and any relevant documents and may submit written

issues, comments and additional medical information within 180 days after you receive notice of an Adverse Benefit Determination or at any time during the claim review process.

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

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

- ***Timing of Appeal Determinations***

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

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

- ***Notice of Appeal Determination***

The Claims Administrator will notify the party filing the appeal, you, and, if a clinical appeal, any health care Provider who recommended the services involved in the appeal, orally of its determination followed-up by a written notice of the determination.

The written notice to you or your authorized representative will include:

- A reason for the determination;
- A reference to the Benefit Plan provisions on which the determination is based, or the contractual, administrative or protocol for the determination;
- Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care Provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available.
- In certain situations, a statement in non-English language(s) that the written notice of the claim denial and certain other Benefit information may be available (upon request) in such non-English language(s);
- In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by the Claims Administrator;
- The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for Benefits;



- Any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
- An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;
- A description of the standard that was used in denying the claim and a discussion of the decision; and
- Contact information for applicable office of health insurance consumer assistance or ombudsman.

## STANDARD EXTERNAL REVIEW

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

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

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

- **Referral to Independent Review Organization.** If your request is eligible for external review and you submit the request within the time period allowed, the Claims Administrator will assign the matter to an independent review organization (IRO). The IRO assigned will be accredited by URAC or by similar nationally-recognized accrediting organization. Moreover, the Claims Administrator will take action against bias and to ensure

independence. Accordingly, the Claims Administrator must contract with at least three IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of Benefits.

The IRO must provide the following:

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

- Any applicable clinical review criteria developed and used by the Claims Administrator, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
  - The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.
- Written notice of the final external review decision must be provided within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the Claims Administrator and you or your authorized representative.
  - The notice of final external review decision will contain:
    - A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care Provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
    - The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
    - References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
    - A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
    - A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Claims Administrator or you or your authorized representative;
    - A statement that judicial review may be available to you or your authorized representative; and
    - Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.
    - After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the Claims Administrator, State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws, and you or your authorized representative.
- **Reversal of Plan's decision.** Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Claims Administrator must immediately provide coverage or payment (including immediately authorizing or immediately paying Benefits) for the claim.

## **EXPEDITED EXTERNAL REVIEW**

- **Request for expedited external review.** The Claims Administrator must allow you or your authorized representative to make a request for an expedited external review with the Claims Administrator at the time you receive:
  - An Adverse Benefit Determination, if the Adverse Benefit Determination involve a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

— A Final Internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

- **Preliminary review.** Immediately upon receipt of the request for expedited external review, the Claims Administrator must determine whether the request meets the reviewability requirements set forth in the “*Standard External Review*” section above. The Claims Administrator must immediately send you a notice of its eligibility determination that meets the requirements set forth in “*Standard External Review*” section above.
- **Referral to independent review organization.** Upon a determination that a request is eligible for external review following the preliminary review, the Claims Administrator will assign an IRO pursuant to the requirements set forth in the “*Standard External Review*” section above. The Claims Administrator must provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

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

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

## EXHAUSTION

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

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

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

## INTERPRETATION OF EMPLOYER’S PLAN PROVISIONS

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

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

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

---

## *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 Claims Administrator's Non-Contracting Allowable Charge as set forth in the *Important Information* section.

**NOTE: For Covered Services received outside the state of Oklahoma, the "Allowable Charge" 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 Blue Cross Blue Shield 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.

### **BENEFIT PERIOD**

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

### **BENEFITS**

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

### **BLUECARD PROVIDER**

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

**CALENDAR YEAR**

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

**COBRA CONTINUATION COVERAGE**

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

**COINSURANCE**

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

**COPAYMENT**

A fixed dollar amount required to be paid by or on behalf of a Covered Person in connection with the delivery of some Covered Services. For Outpatient Prescription Drugs, the Copayment is the dollar amount required to be paid by or on behalf of a Covered Person for each Prescription Order. Refer to the *Schedule of Benefits* for any Copayments applicable to your coverage.

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

**DEPENDENT**

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

**DIAGNOSTIC SERVICE**

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

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

**DURABLE MEDICAL EQUIPMENT**

Equipment which meets the following criteria:

- It is used in the Covered Person's home, place of residence or dwelling;
- It provides therapeutic benefits or enables the Covered Person to perform certain tasks that he or she would be unable to perform otherwise due to certain medical conditions and/or illnesses;

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

**EFFECTIVE DATE**

The date when your coverage begins.

**ELIGIBLE PERSON**

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

**EMERGENCY CARE**

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

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

**EMPLOYEE**

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

City of Oklahoma City by and through the Oklahoma City Municipal Facilities Authority (OCMFA)

**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.

**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.

**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.

**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/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.

**MAINTENANCE PRESCRIPTION DRUG**

A Prescription Drug prescribed for chronic conditions and which is taken on a regular basis to treat conditions such as high cholesterol, high blood pressure or asthma.

**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 judgement, 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.

**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 the Covered Services and to accept the Claims Administrator's Allowable Charge as payment for such Covered Services. Network Providers include BlueCard Providers outside the state of Oklahoma.

**OPEN ENROLLMENT PERIOD**

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

**ORTHOGNATHIC SURGERY**

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

**OUT-OF-NETWORK PROVIDER**

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

**OUT-OF-POCKET LIMIT**

The total amount of Deductibles, Copayments 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.

**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**

City of Oklahoma City by and through the Oklahoma City Municipal Facilities Authority (OCMFA) 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.

### **PREVENTIVE CARE SERVICES**

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

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

### **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. The care is medically monitored, with 24-hour Physician availability and 24-hour onsite nursing services. It does not include half-way houses, supervised living, group homes, boarding houses or other facilities that provide primarily a supportive environment and address long-term social needs.

## **RETAIL HEALTH CLINIC**

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

## **ROUTINE NURSERY CARE**

Ordinary Hospital nursery care of the newborn Covered Person.

## **SKILLED NURSING FACILITY**

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

- Custodial Care, ambulatory or part-time care; or
- Treatment for Mental Illness, alcoholism, drug 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 when used to treat and promote your recovery from an illness or injury:

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

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



BlueCross BlueShield of Oklahoma



*bcbsok.com*

A Division of Health Care Service Corporation a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.  
Blue Cross and Blue Shield of Oklahoma provides administrative services only and does not assume any financial risk or obligation with respond to claims.

70261.0115