Filing at a Glance

Company: Health Care Service Corporation

Product Name: HCSC ET BCBS OK AR
SERFF Tr Num: CMPL-128032181
State: Arkansas

TOI: H16G Group Health - Major Medical
SERFF Status: Closed-Approved
State Tr Num:

Sub-TOI: H16G.001A Any Size Group - PPO
Co Tr Num: HCSC ET BCBS OK AR
State Status: Approved-Closed

Filing Type: Form
Reviewer(s): Donna Lambert
Author: Nancy French
Disposition Date: 01/30/2012
Date Submitted: 01/26/2012
Disposition Status: Approved

Implementation Date Requested: On Approval
Implementation Date: 03/01/2012

State Filing Description:

General Information

Project Name: HCSC ET BCBS OK AR
Status of Filing in Domicile:

Project Number: HCSC ET BCBS OK AR
Date Approved in Domicile:

Requested Filing Mode: Review & Approval
Domicile Status Comments:

Explanation for Combination/Other:
Market Type: Group

Submission Type: New Submission
Group Market Size: Large

Group Market Type: Employer
Overall Rate Impact:

Filing Status Changed: 01/30/2012

State Status Changed: 01/30/2012
Deemer Date:

Created By: Nancy French
Submitted By: Nancy French

Corresponding Filing Tracking Number:

PPACA: Non-Grandfathered Immed Mkt Reforms, Grandfathered Immed Mkt Reforms

PPACA Notes: null

Filing Description:

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January 13, 2012

Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904

Re: Health Care Service Corporation, a Mutual Legal Reserve Company
NAIC# 70670-0917
FEIN# 36-1236610

Group Major Medical Forms – Out Of State Filing
Form Number(s): See enclosed forms list

Dear Commissioner:

Compliance Research Services is pleased to submit the enclosed form son behalf of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC). A letter of filing authorization is enclosed.

The purpose of this filing is to update a previous version of an Arkansas Extraterritorial Benefits Rider which was approved by your Department on May 12, 2011, Form ETGB-AR-HCSC-07, under SERFF Tracking Number: CMPL-125669113. This rider has been updated to more appropriately address defined terms as they are used upon issuance and has been assigned a form number of ETGB-AR-HCSC – 2012. A redlined copy of the Rider is enclosed.

The Arkansas Rider will be used with the enclosed Oklahoma Certificate - form CB-OK-CE et al.

HCSC does business in various states as follows:
• Blue Cross and Blue Shield of Illinois in Illinois;
• Blue Cross and Blue Shield of Texas in Texas;
• Blue Cross and Blue Shield of Oklahoma in Oklahoma; and
• Blue Cross and Blue Shield of New Mexico in New Mexico.

This filing is for HCSC's Oklahoma division however, we will be submitting similar filings for the other divisions of the company.

Submitted Materials. The coverage in question is true group coverage sold in Illinois by licensed Illinois agents and brokers.

The provisions of the certificate may change according to the benefits negotiated between the employer and HCSC.

The enclosed certificate includes provisions for participating provider hospitals and physicians. Coverage may also be issued on a fee for service basis without the network provisions. Individuals insured under network plans have access to their local Blue Cross provider networks under the national Blue Cross association BlueCard plan.

Also enclosed are riders showing proof of compliance with PPACA. The rider for grandfathered plans, Form HCR-GF-GP-1210, was approved by the policy situs state of Oklahoma on December 14, 2010. The non-grandfathered rider, form HCR-NGF-GP-1210, was approved by Oklahoma on January 19, 2011.

Provisions in the certificate that may vary from employer to employer are bracketed. HCSC requests the right to change the type style and paper size or to issue the forms in electronic format.

The forms have been tested for readability. Certification of readability is enclosed.

If you have any questions or comments, please call me at 513-894-6050 or by email at dsimon@crssolutionsgroup.com.

Thank you for your assistance in this matter.

Sincerely,

J. David Simon, CLU
President
Phone: 513.984.6050
Fax: 513.984.7212
E-Mail Address: dsimon@crssolutionsgroup.com

Forms List:

ETGB-AR-HCSC − 2012 Arkansas Extraterritorial Benefits Rider
CB-OK-CE et al Oklahoma Certificate
CB-OK-TC Table of Contents

CB-OK-IN-BC BlueChoice Certificate Insert
CB-OK-IN-BC-NO BlueChoice Certificate Insert
CB-OK-IN-BP BluePreferred Certificate Insert
CB-OK-IN-BO BlueOptions Certificate Insert
CB−OK−IN−BZ BlueOptimize Certificate Insert
CB-OK-IN-BT BlueTraditional Certificate Insert
HCR-GF-GP-1210 Health Care Reform Rider (Grandfathered plans)
HCR-NGF-GP-1210 Health Care Reform Rider (Non-Grandfathered plans)

Company and Contact

Filing Contact Information

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Filing Company Information

(This filing was made by a third party - complianceresearchservicesllc)

Health Care Service Corporation	CoCode: 70670	State of Domicile: Illinois
300 East Randolph Street	Group Code: 917	Company Type:
Chicago, IL 60601	Group Name:	State ID Number:
(513) 984-6050 ext. [Phone]	FEIN Number: 36-1236610	

Filing Fees

Fee Required?	Yes
Fee Amount:	$100.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #

Health Care Service Corporation	$100.00	01/26/2012	55846069

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	01/30/2012	01/30/2012

Disposition

Disposition Date: 01/30/2012

Implementation Date: 03/01/2012

Status: Approved

HHS Status: HHS Approved

State Review: Reviewed-No Actuary

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*CMPL-128032181*	*State:*	*Arkansas*
Filing Company:	*Health Care Service Corporation*	*State Tracking Number:*	
Company Tracking Number:	*HCSC ET BCBS OK AR*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001A Any Size Group - PPO*
Product Name:	*HCSC ET BCBS OK AR*		
Project Name/Number:	*HCSC ET BCBS OK AR/HCSC ET BCBS OK AR*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved	Yes
Supporting Document	Authorization	Approved	Yes
Supporting Document	OK Grandfathered HCR	Approved	Yes
Supporting Document	Certification of Benefit Differential	Approved	Yes
Supporting Document	AR_AR Certif of Compliance with Rule 19	Approved	Yes
Supporting Document	OK Non-grandfathered HCR	Approved	Yes
Form	Arkansas Extraterritorial Benefits Rider	Approved	Yes
Form	Oklahoma Certificate	Approved	Yes

Form Schedule

Lead Form Number: ETGB-AR-HCSC-2012

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 01/30/2012	ETGB-AR-HCSC-2012	Certificate Amendment, Insert Page, Endorsement or Rider	Arkansas Extraterritorial Benefits Rider	Initial		40.000	ET_AR Redlined.pdf
Approved 01/30/2012	CB-OK-CE et al	Certificate	Oklahoma Certificate	Initial		42.000	OK Certificate.pdf

RIDER FOR RESIDENTS OF THE STATE OF ARKANSAS

If you reside permanently in the state of Arkansas, the [Certificate][Benefit Booklet] to which this [rider][Rider] is attached and becomes a part is amended as stated below to conform to the requirements of the state of Arkansas. In the event of a conflict between the [Certificate][Benefit Booklet] and this [rider][Rider], the provisions resulting in greater [benefits][Benefits] will be in effect.

1. **Individual and Family Eligibility**

   The eligibility provision outlining a change in coverage from [individual coverage][Individual Coverage] to [family coverage][Family Coverage] is changed as follows:

   If you apply for a change from [individual coverage][Individual Coverage] to [family coverage][Family Coverage] within 90 days of the birth or within 60 days of the adoption or [placement for adoption][Placement for Adoption] of a [child][Child], your [family coverage][Family Coverage] will be effective from the date of the birth, adoption or [placement for adoption][Placement for Adoption].

   If you do not apply for [family coverage][Family Coverage] within 90 days of the birth or within 60 days of the adoption or [placement for adoption][Placement for Adoption] of a [child][Child], you can make application at any time. The change will be effective on a date that has been mutually agreed to by your [~~Employer~~group][Group] and [Blue Cross and Blue Shield of Illinois][Blue Cross and Blue Shield of Texas][Blue Cross and Blue Shield of New Mexico][Blue Cross and Blue Shield of Oklahoma].

2. **Family Coverage**

   The eligibility provision concerning adding [dependents][Dependents] to [family coverage][Family Coverage] is changed as follows**:**

   If you apply to add your newborn [child][Child] to your [family coverage][Family Coverage] within 90 days of the [child's][Child's] birth or to add your adopted [child][Child] or [child][Child] placed for adoption to your [family coverage][Family Coverage] within 60 days of the adoption or [placement for adoption][Placement for Adoption], coverage for your [dependent][Dependent]will be effective from the date of the birth, adoption or [placement for adoption][Placement for Adoption].

   If you do not apply to add your newborn within 90 days of the birth, or your adopted [child][Child] within 60 days of the adoption or [placement for adoption][Placement for Adoption], you can make application at any time. The change will be effective on a date that has been mutually agreed to by your [~~Employer~~group][Group] and [Blue Cross and Blue Shield of Illinois][Blue Cross and Blue Shield of Texas][Blue Cross and Blue Shield of New Mexico][Blue Cross and Blue Shield of Oklahoma].

3. Mentally and Physically Handicapped Children

Benefits are provided for your [dependent][Dependent] [child][Child] after they reach the limiting age if the [dependent][Dependent] [child][Child] is incapable of self–sustaining employment by reason of mental or physical handicap; became incapacitated prior to the attainment of age 19; and is chiefly dependent on you for support and maintenance. Proof of the incapacity and dependency must be furnished to [Blue Cross and Blue Shield of Illinois][Blue Cross and Blue Shield of Texas][Blue Cross and Blue Shield of New Mexico][Blue Cross and Blue Shield of Oklahoma].

4. Providers

Benefits for the following [providers][Providers] will be paid at the same level as other [providers][Providers].

- [Advanced practice nurses][Advanced Practice Nurses].
- Athletic trainers.
- [Audiologists][Licensed Audiologists].
- Certified orthotists.
- [Chiropractors][Doctors of Chiropractic].
- Community mental health centers or clinics.
- [Dentists][Doctors of Dentistry]
- [Home health care][Home Health Care][Coordinated Home Care].
- Hospice care.
- Hospital–based service.
- Hospitals.
- Licensed ambulatory surgery centers.
- Licensed [social workers][Clinical Social Workers].
- Licensed [dieticians][Dieticians].
- Licensed [professional counselors][Professional Counselors].
- Licensed psychological examiners.
- Long–term care facilities
- Nurse Anesthetists
- [Occupational therapists][Licensed Occupational Therapists][Occupational Therapists].
- Optometrists.

- Pharmacists.
- [Physical therapists][Licensed Physical Therapists][Physical Therapists].
- Physicians and surgeons (M.D. and D.O.).
- [Podiatrists][Doctors of Podiatry].
- Prostheticists.
- [Psychologists][Doctors of Psychology].
- Respiratory therapists.
- Rural health clinics; and
- [Speech pathologists][Licensed Speech–Language Pathologists].

In addition, benefits will be provided for non–[hospital][Hospital] based medical facilities providing clinical diagnostic services for sleep disorder, and non–[hospital][Hospital] based medical [facilities][Facilities] providing magnetic resonance imaging, computed axial tomography, or other imaging diagnostic testing.

5. Well Child Care

Benefits will be provided for [Ceovered Ceharges][Allowable Charges][Allowable Amounts][Eligible Charges][eligible expenses] rendered by a [physician][Physician] to [children][Children] under age 19, even though they are not ill. Benefits will be limited to the following services:

- Immunizations;
- Routine diagnostic tests;
- 20 physical examinations at approximately the following age intervals:
    - Birth,
    - Two weeks,
    - Two months,
    - Four months,
    - Six months,
    - Nine months,
    - 12 months,
    - 15 months,
    - 18 months,
    - Two years,

- Three years,
- Four years,
- Five years,
- Six years,
- Eight years,
- 10 years,
- 12 years,
- 14 years,
- 16 years, and
- 18 years.

Benefits will not be subject to any [copayment][Copayment][Copayment Amount], [deductible][Deductible], [coinsurance][Coinsurance][Coinsurance Amount] or [benefit period][Benefit Period] dollar maximum.

6. Mammograms

If your [~~employer~~][~~Employer~~group][Group] elects to cover mammograms, benefits will be provided as follows:

- A base line mammogram for a female who is at least 35 years of age but less than 40 years of age;
- One mammogram every one to two years for a female who is from 40 to 49 years of age; and
- One mammogram a year for a female who is at least 50 years of age; or
- A mammogram upon recommendation of a woman's [physician][Physician], without regard to age, when the woman has had a prior history of breast cancer or when the woman's mother or sister has had a history of breast cancer.

Benefits are not subject to a [deductible][Deductible],[copayment][Copayment][Copayment Amount] or the [coinsurance][Coinsurance][Coinsurance Amount].

7. Colorectal Cancer

Benefits will be provided for colorectal cancer examinations as follows:

- If you are more than 50 years of age;
- If you are age 50 and under and are at high risk for colorectal cancer according to the American Cancer Society colorectal cancer screening guidelines; or

- If you are experiencing bleeding from the rectum or blood in the stool, or if you have a change in bowel habits such as diarrhea, constipation or narrowing of the stool that lasts for more than five days.

Colorectal screening shall involve an examination of the entire colon including the following:

- An annual fecal occult blood test utilizing the take–home multiple sample method, or an annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every five years;
- A double–contrast barium enema every five years; or
- A colonoscopy every ten years; and
- Any additional medically recognized screening tests for colorectal cancer required the Director of the Department of Health.

Benefits are not subject to a [deductible][Deductible],[copayment][Copayment][Copayment Amount] or the [coinsurance][Coinsurance][Coinsurance Amount].

8. Prostate Cancer

Benefits will be provided for at least one screening per year for any man 40 years of age or older according to the National Comprehensive Cancer Network guidelines. Benefits are not subject to a [deductible][Deductible],[copayment][Copayment][Copayment Amount] or the [coinsurance][Coinsurance][Coinsurance Amount].

9. Phenylketonuria Treatment

Benefits will be provided for amino acid modified preparations, low protein modified food products and any other special dietary products and formulas prescribed by a [physician][Physician] for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism.

10. Musculoskeletal Disorders

Benefits will be provided for the surgical and non–surgical treatment of musculoskeletal disorders affecting any bone or joint in the face, neck or head including [temporomandibular joint syndrome][temporomandibular joint dysfunction][Temporomandibular Joint Dysfunction]] and craniomandibular disorder. Your [benefits][Benefits] for musculoskeletal disorders are the same as your [benefits][Benefits] for any other condition.

11. In Vitro Fertilization

Benefits will be provided for in vitro fertilization procedures for you or your [dependent][Dependent] spouse when:

- Your or your spouse's oocytes are fertilized with the sperm of you or your spouse, and

- You or your spouse have a history of unexplained infertility of at least two years duration; or
- The infertility is associated with one or more of the following medical conditions:
    - Endometriosis;
    - Exposure in utero to diethylstilbestrol, commonly known as DES;
    - Blockage of or removal of one or both fallopian tubes that is not a result of voluntary sterilization; or
    - Abnormal male factors contributing to the infertility.
- The in vitro fertilization procedures are performed at a [facility][Facility] licensed or certified by the Arkansas Department of Health which conforms to the standards of the American College of Obstetricians and Gynecologists', or are performed at a [facility][Facility] certified by the Arkansas Department of Health which meet the American Fertility Society's minimal standards for programs of in vitro fertilization.
- You or your spouse has been unable to obtain successful pregnancy through any less costly infertility treatment for which coverage is available under the [group health plan][Group Health Plan][Group Policy][Health Benefit Plan].

The [benefits][Benefits] for in vitro fertilization are the same as the [benefits][Benefits] provided under [maternity][Maternity] [benefit][Benefit] provisions. Cryopreservation, the procedure whereby embryos are frozen for late implantation, is included as an in vitro fertilization procedure.

12. Diabetes Supplies and Training

The provision related to the treatment of diabetes is revised to provide [benefits][Benefits] for blood glucose monitors, blood glucose monitors for the legally blind, test strips (for monitors, glucose control solutions, lancet devices and lancets), visual reading and urine testing strips, insulin, injection aids, syringes, insulin pumps an supplies (such as skin preparations, adhesive supplies, infusion sets, cartridge and batteries) oral agents for controlling blood sugar, podiatric appliances for prevention of complications associated with diabetes (including therapeutic molded or depth–inlay shoes, replacement inserts, preventive devices and shoe modifications for prevention and treatment) and glucagon emergency kits. In addition, [benefits][Benefits] will be provided for [inpatient][Inpatient] and [outpatient][Outpatient] self–management training and education, including medical nutrition therapy, relating to diet, caloric intake and diabetes management but excluding programs the primary purposes of which are weight reduction.

13. Maternity Care

The coverage for [Maternity Services][Maternity Care][maternity care] is changed to allow [routine nursery care][Routine Nursery Care] and pediatric charges for a well newborn [child][Child] for up to five full days in a [hospital][Hospital] nursery or until the mother is discharged from the [hospital][Hospital] following the birth.

14. Cancer Treatment

Benefits will be provided for drugs used for the treatment of cancer if:

- The drug has been approved by the federal Food and Drug Administration for the treatment of the specific type of cancer for which it has been prescribed; and
- The drug is recognized for treatment of that specific type of cancer in one of the standard reference compendia or in the medical literature.

15. Hearing Aids

Benefits will be provided for a hearing aid or hearing instrument sold by a licensed professional. The coverage for hearing aids shall be for not less than $1,400 per ear, and is not subject to [deductibles][Deductibles] or [copayments][Copayments][Copayment Amounts].

16. Anesthesia and Dental Procedures

Benefits will be provided for anesthesia, [hospital][Hospital] or [ambulatory surgical facility][Ambulatory Surgical Facility] charges for dental procedures if it is certified that general anesthesia is required to safely perform the procedures and the patient is:

- A [child][Child] under seven years of age who is determined by two licensed [dentists][Dentists] to require without delay necessary dental treatment in a [hospital][Hospital] or [ambulatory surgical facility][Ambulatory Surgical Facility] for a significantly complex dental condition;
- A person with a diagnosed serious physical condition or [mental illness][Mental Illness][Mental Health Care disorder]; or
- A person with a significant behavioral problem as determined by your [physician][Physician].

17. Contraceptive Drugs and Devices

If your coverage provides benefits for prescription drugs on [outpatient][Outpatient] basis, then [benefits][Benefits] will be provided for [prescription drugs][Prescription Drugs] or devices approved by the United States Food and Drug Administration for use as a contraceptive. A religious organization is not required to provide this [benefit][Benefit]. A "religious employer" means an entity that: (1) is organized and

operated for religious purposes and has received a section 501(c)(3) designation from the Internal Revenue Service; (2) has as one of its primary purposes the inculcation of religious values; and (3) employs primarily persons who share its religious tenets.

18. Late Claim Payments

The interest rate for a [claim][Claim] not paid on time by the claim administrator is 12%.

19. Continuation of Coverage

If you have been insured continuously under this [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] for at least three months and your coverage has been terminated for any reason other than nonpayment of the required contribution, you may continue coverage under this [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] for an additional three months. You must request continuation in writing no later than 10 days after the termination of employment or membership or a change in marital status. You must pay the entire premium including any portion paid by your former [~~employer][Employer~~group][Group]. Continuation of coverage is subject to the [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] or a successor [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] remaining in force.

Continuation of coverage shall end at the earliest of the following dates:

- 120 days after continuation of coverage begins;
- The end of the period for which the individual made a timely contribution;
- The contribution due date following the date the individual becomes eligible for Medicare; or
- The date on which the [policy][contract] is terminated or the [group][Group] withdraws from the [group health plan][Group Health Plan][Group Policy][Health Benefit Plan].

20. Conversion Privilege

If your coverage under this [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] should terminate for any reason, including the discontinuance of the [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] in its entirety, and you want to continue [Blue Cross and Blue Shield of Illinois][Blue Cross and Blue Shield of Texas][Blue Cross and Blue Shield of New Mexico][Blue Cross and Blue Shield of Oklahoma] coverage with no interruption, you may do so if your [~~Employer~~group][Group] has not cancelled this coverage and replaced it with other coverage. Here is what to do:

1. Tell [Blue Cross and Blue Shield of Illinois][Blue Cross and Blue Shield of Texas][Blue Cross and Blue Shield of New Mexi-

co][Blue Cross and Blue Shield of Oklahoma] or your [group][Group] administrator that you wish to continue your coverage and you will be provided with the necessary application.

2. Send the application and first premium to [Blue Cross and Blue Shield of Illinois][Blue Cross and Blue Shield of Texas][Blue Cross and Blue Shield of New Mexico][Blue Cross and Blue Shield of Oklahoma] within 31 days of the date you leave your [~~employer][Employer][~~group][Group] or within 15 days after you have been given written notice of the conversion privilege, but in no event later than 60 days after you leave your [~~employer][Employer][~~group][Group].

Having done so, you will then be covered by [Blue Cross and Blue Shield of Illinois][Blue Cross and Blue Shield of Texas][Blue Cross and Blue Shield of New Mexico][Blue Cross and Blue Shield of Oklahoma] on an individual "direct pay" basis. This coverage will be effective from the date your coverage under this [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] terminates so long as the premiums charged for the direct pay coverage are paid when due.

These direct pay [benefits][Benefits] (and the premium charged for them) may not be exactly the same as the [benefits][Benefits] under the [group health plan][Group Health Plan][Group Policy][Health Benefit Plan]. However, by converting your coverage, your [benefits][Benefits] under the [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] are not interrupted and you will not have to repeat [waiting periods][Waiting Periods] (if any).

[Should any or all of your [dependents][Dependents] become ineligible for coverage under this [group health plan][Group Health Plan][Group Policy][Health Benefit Plan], they may convert to direct pay coverage by following the instructions stated above.]

3. Coordination of Benefits

DEFINITIONS

A. A [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] is any of the following that provides [benefits][Benefits] or services for medical or dental care or treatment. If separate [contracts][Contracts] are used to provide coordinated coverage for [members][Members] of a [group][Group], the separate [contracts][Contracts] are considered parts of the same [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] and there is no coordination of benefits (COB) among those separate [contracts][Contracts].

(1) A [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] includes: [group][Group] and nongroup [contracts][Contracts], [health maintenance organization][Health Mainte-

nance Organization] (HMO) [contracts][Contracts], closed panel plans or other forms of [group][Group] coverage (whether insured or uninsured); [medical care][Medical Care] components of [long term care][Long Term Care] [contracts][Contracts], such as [skilled nursing care][Skilled Nursing Care]; medical benefits under [group][Group] or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

(2) A [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] does not include: [hospital][Hospital] indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non–medical components of [long term care][Long Term Care] policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law. Each [contract][Contract] for coverage under (1) or (2) is a separate [group health plan][Group Health Plan][Group Policy][Health Benefit Plan]. If a [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate [group health plan][Group Health Plan][Group Policy][Health Benefit Plan].

B. This [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] means, in a COB provision, the part of the [contract][Contract] providing the health care benefits to which the COB provision applies and which may be reduced because of the [benefits][Benefits] of other [group health plan][Group Health Plan][Group Policy][Health Benefit Plan]. Any other part of the [contract][Contract] providing health care benefits is separate from this [group health plan][Group Health Plan][Group Policy][Health Benefit Plan]. A [contract][Contract] may apply one COB provision to certain [benefits][Benefits], such as dental [benefits][Benefits], coordinating only with similar [benefits][Benefits], and may apply another COB provision to coordinate other [benefits][Benefits].

C. The order of [benefit][Benefit] determination rules determine whether this [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] is a primary plan or secondary plan when the person has health care coverage under more than one [group health plan][Group Health Plan][Group Policy][Health Benefit Plan]. When this [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] is primary, it determines payment for its [benefits][Benefits] first before those of any other [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] without considering any other [group health plan's][Group Health Plan's][Group Policy's][Health Benefit Plan's] [benefits][Benefits]. When this [group health plan][Group Health Plan][Group Policy][Health Bene-

fit Plan] is secondary, it determines its [benefits][Benefits] after those of another [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] and may reduce the [benefits][Benefits] it pays so that all [benefits][Benefits] do not exceed 100% of the total allowable expense.

D. Allowable expense is a health care expense, including [deductibles][Deductibles], [coinsurance][Coinsurance][Coinsurance Amounts] and [copayments][Copayments][Copayment Amounts], that is covered at least in part by any [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] covering the person. When a [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] provides [benefits][Benefits] in the form of services, the reasonable cash value of each service will be considered an allowable expense and a [benefit][Benefit] paid. An expense that is not covered by any [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] covering the person is not an allowable expense. In addition, any expense that a [provider][Provider] by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense. The following are examples of expenses that are not allowable expenses:

(1) The difference between the cost of a semi–private [hospital][Hospital] room and a private [hospital][Hospital] room is not an allowable expense, unless one of the [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] provides coverage for private [hospital][Hospital] room expenses.

(2) If a person is covered by two or more [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] that compute their [benefit][Benefit] payments on the basis of [usual and customary][Usual and Customary] fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific [benefit][Benefit] is not an allowable expense.

(3) If a person is covered by two or more [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] that provide [benefits][Benefits] or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.

(4) If a person is covered by one [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] that calculates its [benefits][Benefits] or services on the basis of [usual and customary][Usual and Customary] fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] that provides its [benefits][Benefits] or

services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all [group health plans][Group Health Plans][Group Policies][Health Benefit Plans]. However, if the [provider][Provider] has contracted with the secondary plan to provide the [benefit][Benefit] or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the [provider's][Provider's] [contract][Contract] permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its [benefits][Benefits].

(5) The amount of any [benefit][Benefit] reduction by the primary plan because a covered person has failed to comply with the [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, [preadmission review] [precertification][Precertification] [Preauthorization] of [admissions] [Admissions], and [preferred provider][Preferred Provider] arrangements.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more [group health plans][Group Health Plans][Group Policies][Health Benefit Plans], the rules for determining the order of [benefit][Benefit] payments are as follows:

A. The primary plan pays or provides its [benefits][Benefits] according to its terms of coverage and without regard to the [benefits][Benefits] under any other [group health plan][Group Health Plan][Group Policy][Health Benefit Plan].

B. (1) Except as provided in Paragraph (2), a [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] state that the complying [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] is primary.

(2) Coverage that is obtained by virtue of membership in a [group][Group] that is designed to supplement a part of a basic package of [benefits][Benefits] and provides that this supplementary coverage shall be excess to any other parts of the [group health plans][Group Health Plans][Group Policies][Health Benefit Plans] provided by the [contract][Contract] holder. Examples of these types of situations are major medical coverages that are superimposed over base plan [hospital][Hospital] and surgical [benefits][Benefits], and insurance type coverages that are written in connection with a closed panel plan to provide [out–of–network][Out–of–Network] [benefits][Benefits].

EFFECT ON THE BENEFITS OF THIS PLAN

A. When this [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] is secondary, it may reduce its [benefits][Benefits] so that the total [benefits][Benefits] paid or provided by all [group health plans][Group Health Plans][Group Policies][Health Benefit Plans] during a plan year are not more than the total allowable expenses. In determining the amount to be paid for any [claim][Claim], the secondary plan will calculate the [benefits][Benefits] it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total [benefits][Benefits] paid or provided by all [benefits][Benefits] for the [claim][Claim] do not exceed the total allowable expense for that [claim][Claim]. In addition, the secondary plan shall credit to its plan [deductible][Deductible] any amounts it would have credited to its [deductible][Deductible] in the absence of other health care coverage.

B. If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non–panel Provider, [benefits][Benefits] are not payable by one closed panel plan, COB shall not apply between that [group health plan][Group Health Plan][Health Benefit Plan] and other closed panel plans.

FACILITY OF PAYMENT

A payment made under another [group health plan][Group Health Plan][Group Policy][Health Benefit Plan] may include an amount that should have been paid under this [group health plan][Group Health Plan][Group Policy][Health Benefit Plan]. If it does, [Blue Cross and Blue Shield of Illinois][Blue Cross and Blue Shield of Texas][Blue Cross and Blue Shield of New Mexico][Blue Cross and Blue Shield of Oklahoma] may pay that amount to the organization that made that payment. That amount will then be treated as though it were a [benefit][Benefit] paid under this [group health plan][Group Health Plan][Group Policy][Health Benefit Plan]. [Blue Cross and Blue Shield of Illinois][Blue Cross and Blue Shield of Texas][Blue Cross and Blue Shield of New Mexico][Blue Cross and Blue Shield of Oklahoma] will not have to pay that amount again. The term "payment made" includes providing [benefits][Benefits] in the form of services, in which case "payment made" means the reasonable cash value of the [benefits][Benefits] provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by [Blue Cross and Blue Shield of Illinois][Blue Cross and Blue Shield of Texas][Blue Cross and Blue Shield of New Mexico][Blue Cross and Blue Shield of Oklahoma] is

more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the [benefits][Benefits] or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any [benefits][Benefits] provided in the form of services.

Except as amended by this [rider][Rider], all terms, conditions, limitations and exclusions of the [Certificate][Benefit Booklet] to which this [rider][Rider] is attached will remain in full force and effect.

[Attest:

Health Care Service Corporation
a Mutual Legal Reserve Company
(Blue Cross and Blue Shield of Illinois)
(Blue Cross and Blue Shield of Texas)
(Blue Cross and Blue Shield of New Mexico)
(Blue Cross and Blue Shield of Oklahoma)

Thomas C. Lubben
Secretary

Patricia A. Hemingway Hall
President]

BlueChoice
Certificate Insert

Your Benefits under this program are subject to the following provisions:

OFFICE VISIT COPAYMENT	$[0–100] for each visit to a BlueChoice PPO Physician's office.
DEDUCTIBLE	[$[100–10,000] per Benefit Period per Subscriber.]
[Out–of–Network Hospital Deductible	$ [100–5,000] per Inpatient Hospital Admission.]
[Hospital Admission Deductible	$[100–5,000] for each visit to a Hospital.]
[Emergency Room Deductible	$[50–1,000] for each visit to a Hospital emergency room.]
[Outpatient Surgery Deductible	$[100–5,000] for each visit to an Outpatient facility for Surgery.]
[Benefit Period Deductible	$[100–10,000] per Benefit Period per Subscriber.]
[**STOP-LOSS LIMIT**] [**OUT-OF-POCKET LIMIT**]	[$[1,000–100,000] per Benefit Period per Subscriber.]
[BlueChoice PPO and BlueCard PPO Provider Services	$[1,000–100,000] per Benefit Period per Subscriber.]
[Out–of–Network Provider Services	$[1,000–100,000] per Benefit Period per Subscriber.]
[**OPTIONAL ACCIDENTAL INJURY SERVICES**	$[100–5,000] per Benefit Period per Subscriber.]

Refer to this Certificate for additional provisions applicable to your coverage.

KEEP THIS PAGE WITH YOUR CERTIFICATE FOR FUTURE REFERENCE.

BlueChoice
Certificate Insert

Your Benefits under this program are subject to the following provisions:

DEDUCTIBLE	[$[100–10,000] per Benefit Period per Subscriber.]
[Out–of–Network Hospital Deductible	$ [100–5,000] per Inpatient Hospital Admission.]
[Hospital Admission Deductible	$[100–5,000] for each visit to a Hospital.]
[Emergency Room Deductible	$[50–1,000] for each visit to a Hospital emergency room.]
[Outpatient Surgery Deductible	$[100–5,000] for each visit to an Outpatient facility for Surgery.]
[Benefit Period Deductible	$[100–10,000] per Benefit Period per Subscriber.]
[**STOP-LOSS LIMIT**] [**OUT-OF-POCKET LIMIT**]	[$[1,000–100,000] per Benefit Period per Subscriber.]
[BlueChoice PPO and BlueCard PPO Provider Services	$[1,000–100,000] per Benefit Period per Subscriber.]
[Out–of–Network Provider Services	$[1,000–100,000] per Benefit Period per Subscriber.]
[**OPTIONAL ACCIDENTAL INJURY SERVICES**	$[100–5,000] per Benefit Period per Subscriber.]

Refer to this Certificate for additional provisions applicable to your coverage.

KEEP THIS PAGE WITH YOUR CERTIFICATE FOR FUTURE REFERENCE.

BluePreferred
Certificate Insert

Your Benefits under this program are subject to the following provisions:

OFFICE VISIT COPAYMENT	$[0–100] for each visit to a BluePreferred PPO Physician's office.
DEDUCTIBLE	[$[100–10,000] per Benefit Period per Subscriber.]
[**Out–of–Network Hospital Deductible**	$[100–5,000] per Inpatient Hospital Admission.]
[**Hospital Admission Deductible**	$[100–5,000] for each visit to a Hospital.]
[**Emergency Room Deductible**	$[50–1,000] for each visit to a Hospital emergency room.]
[**Outpatient Surgery Deductible**	$[100–5,000] for each visit to an Outpatient facility for Surgery.]
[**Benefit Period Deductible**	[$[100–10,000] per Benefit Period per Subscriber.]
[BluePreferred and BlueCard PPO Provider Services Deductible	$[100–10,000] per Benefit Period per Subscriber.]
[Out–of–Network Provider Services Deductible	$[100–10,000] per Benefit Period per Subscriber.]
[**STOP-LOSS LIMIT**] [**OUT-OF-POCKET LIMIT**]	[$[1,000–100,000] per Benefit Period per Subscriber.]
[BluePreferred and BlueCard PPO Provider Services	$[1,000–100,000] per Benefit Period per Subscriber.]
[Out–of–Network Provider Services	$[1,000–100,000] per Benefit Period per Subscriber.]
[**OPTIONAL ACCIDENTAL INJURY SERVICES**	$[100–5,000] per Benefit Period per Subscriber.]

Refer to this Certificate for additional provisions applicable to your coverage.

KEEP THIS PAGE WITH YOUR CERTIFICATE FOR FUTURE REFERENCE.

BlueOptions
Certificate Insert

Your Benefits under this program are subject to the following provisions:

OFFICE VISIT COPAYMENT	$[0–100] for each visit to a Physician's office.
DEDUCTIBLE	[$[100–10,000] per Benefit Period per Subscriber.]
[Emergency Room Deductible	$[50–1,000] for each visit to a Hospital emergency room.]
[Outpatient Surgery Deductible	$[100–5,000] for each visit to an Outpatient facility for Surgery.]
[Hospital Admission Deductible	$[100–5,000] for each visit to a Hospital.]
[Benefit Period Deductible	$[100–10,000] per Benefit Period per Subscriber.]
[**STOP-LOSS LIMIT**] [**OUT-OF-POCKET LIMIT**]	[$[1,000–100,000] per Benefit Period per Subscriber.]

Refer to this Certificate for additional provisions applicable to your coverage.

KEEP THIS PAGE WITH YOUR CERTIFICATE FOR FUTURE REFERENCE.

BlueOptimize
Certificate Insert

Your Benefits under this program are subject to the following provisions:

OFFICE VISIT COPAYMENT	$[0–100] for each visit to a Physician's office.
DEDUCTIBLE	[$[100–10,000] per Benefit Period per Subscriber.]
[Emergency Room Deductible	$[50–1,000] for each visit to a Hospital emergency room.]
[Outpatient Surgery Deductible	$[100–5,000] for each visit to an Outpatient facility for Surgery.]
[Hospital Admission Deductible	$[100–5,000] for each visit to a Hospital.]
[Benefit Period Deductible	$[100–10,000] per Benefit Period per Subscriber.]
[**STOP-LOSS LIMIT**] [**OUT-OF-POCKET LIMIT**]	[$[1,000–100,000] per Benefit Period per Subscriber.]

Refer to this Certificate for additional provisions applicable to your coverage.

KEEP THIS PAGE WITH YOUR CERTIFICATE FOR FUTURE REFERENCE.

BlueTraditional
Certificate Insert

Your Benefits under this program are subject to the following provisions:

DEDUCTIBLE	[$[100–10,000] per Benefit Period per Subscriber.]
[Out–of–Network Hospital Deductible	$[100–5,000] per Inpatient Hospital Admission.]
[Hospital Admission Deductible	$[100–5,000] for each visit to a Hospital.]
[Emergency Room Deductible	$[50–1,000] for each visit to a Hospital emergency room.]
[Outpatient Surgery Deductible	$[100–5,000] for each visit to an Outpatient facility for Surgery.]
[Benefit Period Deductible	$[100–10,000] per Benefit Period per Subscriber.]
[**STOP-LOSS LIMIT**] [**OUT-OF-POCKET LIMIT**]	[$[1,000–100,000] per Benefit Period per Subscriber.]
[**OPTIONAL ACCIDENTAL INJURY SERVICES**	$[100–5,000] per Benefit Period per Subscriber.]

Refer to this Certificate for additional provisions applicable to your coverage.

KEEP THIS PAGE WITH YOUR CERTIFICATE FOR FUTURE REFERENCE.

Table of Contents

Certificate

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

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

Your Group has contracted with **Blue Cross and Blue Shield of Oklahoma** (called the Plan, we, us, or our) to provide the Benefits described in this Certificate. Blue Cross and Blue Shield of Oklahoma, having issued a Group Contract to the Group, certifies that all persons who have:

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

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

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

[**Signature**]

President of Blue Cross and Blue Shield of Oklahoma

Your Subscriber Identification Number: _____

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

Important Information

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

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

[THE BLUEPREFERRED PROVIDER NETWORK

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

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

[HOW YOUR BLUEPREFERRED COVERAGE WORKS

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

The BluePreferred program 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 Subscribers use these BluePreferred Providers, they will have less out–of–pocket expense.

In contrast, when care is received from a Physician who is not a member of the BluePreferred Provider network, a *higher* Coinsurance and [Stop–Loss Limit][Out–of–Pocket Limit] will apply to most Covered Services. [Also, if you receive *Inpatient* care from a Hospital that is not a BluePreferred Provider, you will be responsible for a separate $[100–1,000]Deductible for each Hospital Admission (in addition to your Benefit Period Deductible).]]

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

[THE BLUECHOICE PPO PROVIDER NETWORK

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

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

[How Your BlueChoice PPO Coverage Works

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

The BlueChoice PPO program 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 Subscribers use these BlueChoice PPO Providers, they will have less out–of–pocket expense.

In contrast, when care is received from a Physician who is not a member of the BlueChoice PPO Provider network, a *higher* Coinsurance and [Stop–Loss Limit][Out–of–Pocket Limit] will apply to most Covered Services. [Also, if you receive *Inpatient* care from a Hospital that is not a BlueChoice PPO Provider, you will be responsible for a separate $[100–1,000] Deductible for each Hospital Admission (in addition to your Benefit Period Deductible).]

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

[Your Participating Provider Networks

[BlueOptions] [BlueOptimize] is a Preferred Provider Organization (PPO) plan that offers the widest choices of network Physicians and Hospitals, yet is priced significantly lower than most standard PPO plans. Blue Cross and Blue Shield of Oklahoma has negotiated special agreements with Hospitals, Outpatient facilities, Physicians and other health care Providers from many specialties. These participating health care professionals work with Blue Cross and Blue Shield of Oklahoma to help keep down the cost of health care. Although you are free to choose any health care Provider for your services, your [BlueOptions] [BlueOptimize]coverage will provide the highest level of Benefits if you use a BluePreferred Provider.

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

[How Your [BlueOptions] [BlueOptimize] Coverage Works

With [BlueOptions] [BlueOptimize], you have the freedom to choose your Physician every time you seek care.

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

[BlueOptions] [BlueOptimize] features four different coverage levels:

- **BluePreferred Provider Services** — Most Covered Services are paid at [50–100]% of the Allowable Charge, after you satisfy any Copayment and/or Deductibles.

- **BlueChoice Provider Services** — Most Covered Services are paid at [50–100]% of the Allowable Charge, after you satisfy any Copayment and/or Deductibles.
- **BlueTraditional Provider Services** — Most Covered Services are paid at [50–100] % of the Allowable Charge, after you satisfy any Copayment and/or Deductibles.
- **Out–of–NetworkProvider Services** — Most Covered Services are paid at [50–100]% of the Allowable Charge, after you satisfy any Copayment and/or Deductibles. You will also be responsible for any charges which exceed the Plan's allowance for Covered Services.]

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

[BlueTraditional – A Participating Provider Network

BlueTraditional is a network of participating Providers of health care who have agreed to work with Blue Cross and Blue Shield of Oklahoma to help hold the line on health care cost increases. BlueTraditional consists of professionals from many medical areas – Physicians of all specialties, Hospitals, Ambulatory Surgical Facilities, Home Health Care Agencies, ambulance companies and many other health care professionals.

Here's how using a BlueTraditional Provider can benefit you:

- BlueTraditional Providers will file your claims for you.
- Payment for Covered Services will be sent directly to the BlueTraditional Provider.
- For Covered Services, you only have to pay your Deductible and any Coinsurance amounts which may apply to your coverage. If your BlueTraditional Provider charges more than our allowance for Covered Services, you aren't responsible for the difference.

Using BlueTraditional Providers can save you time and money. If you have any questions about the BlueTraditional network, contact a Blue Cross and Blue Shield of Oklahoma Customer Service Representative at [1–800–942–5837].

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

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

Selecting a Provider

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

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

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

When you call Blue Cross and Blue Shield of Oklahoma, ask our Customer Service Representative whether or not the Provider is a network Provider. Simply call our toll–free number at [1–800–942–5837].

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

THE BLUECARD [PPO]PROGRAM

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

- **Finding a [PPO]Physician or Hospital**

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

- **Available Care Coast to Coast**

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

- **Remember to Always Carry the BlueCard**

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

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

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

[How The BlueCard[PPO] Program Works

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

[Your Prescription Drug Program

Blue Cross and Blue Shield of Oklahoma has contracted with a network of Participating Pharmacies to help hold the line on the increasing costs of Prescription Drugs.

[How Your Prescription Drug Program Works

- Show your Blue Cross and Blue Shield of Oklahoma Identification Card to your Pharmacy.
- If you choose a Participating Pharmacy, you will receive a discounted price for your prescriptions and your claims are filed automatically!
- Blue Cross and Blue Shield of Oklahoma will process your claims, subtract any Deductible and/or Coinsurance amounts which apply to your covered prescriptions, and forward the balance directly to you.]

[In order to receive the highest level of Benefits for your prescription charges, *your prescriptions must be filled at a Participating Pharmacy.* **Your coverage under this program is subject to a reduction in Benefits if your prescriptions are filled at a Pharmacy which is not a member of the Participating Pharmacy network.**]

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

REMEMBER — Using Participating Pharmacies can save you time and money. If you have any questions about your Prescription Drug coverage, please call a Customer Service Representative at the following number [1–800–942–5837.]]

[YOUR PRESCRIPTION DRUG PROGRAM

[To receive the highest level of Benefits under this program, always have your prescriptions filled by a Participating Pharmacy.]

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

[HOW YOUR PRESCRIPTION DRUG PROGRAM WORKS

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

REMEMBER — Using Participating Pharmacies can save you time and money. If you have any questions about your Prescription Drug coverage, please call a Customer Service Representative at [1–800–942–5837.]

[In order to receive the highest level of Benefits for your prescription charges, *your prescriptions must be filled at a Participating Pharmacy.* **Your coverage under this Certificate is subject to a reduction in Benefits if your prescriptions are filled at an Out–of–Network Pharmacy.**]

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

[PREFERRED PRESCRIPTION DRUG PROGRAM

To help our Subscribers make the most of their Prescription Drug Benefits, Blue Cross and Blue Shield of Oklahoma has implemented a Preferred Prescription Drug Program. While many prescriptions have generic equivalents, most do not. Prescriptions without a generic equivalent tend to be much more expensive than those with a generic alternative.

This program was designed to help you and your Physician select a safe, cost effective medication for your condition without limiting your freedom of choice. Your Prescription Drug Benefit program has multiple Copayment options for your prescriptions. The choice of drugs is up to you and your Physician. Generic Drugs are available at the lowest Copayment amount, Preferred Drugs are available at the next lowest Copayment level and the Non–Preferred Brand Drugs are available at the highest Copayment/Coinsurance level.

Subscribers will receive a listing of Preferred Drugs upon enrollment. This listing is maintained by the Pharmacy and Therapeutics Committee and will be changed periodically. You may call a Customer Service Representative to request an updated listing at [1–800–942–5837.]]

[Your Participating Dental Network

Blue Cross and Blue Shield of Oklahoma Subscribers have access to thousands of Participating Dentists nationwide. Here's how using a Participating Dentist can benefit you:

- A Participating Dentist will file your claims for you.
- Payment for Covered Services you receive will be sent directly to the Participating Dentist.
- For Covered Services, you only have to pay your shared payment amount. **If your Participating Dentist charges more than our allowance for Covered Services, you aren't responsible for the difference.**

Subscribers living or traveling outside the state of Oklahoma may show their Identification Card to receive full, in–network Benefits from any Participating Dentist nationwide.

To locate a Participating Dentist, please call one of our Customer Service Representatives at [1–888–381–9727]. You may also look up in–state (Oklahoma) and out–of–state Dentists on the "Provider Directory" section of the Blue Cross and Blue Shield of Oklahoma Web site at [www.bcbsok.com].]

Medical Necessity Limitation

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

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

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

Precertification

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

For an Inpatient facility stay, *you must request Precertification from the Plan* ***before*** *your scheduled admission*. The Plan will consult with your Physician, Hospital, or other facility to determine if Inpatient level of care is required for your illness or injury. The Plan may decide that the treatment you need could be provided just as effectively in a less expensive setting (such as the Outpatient department of the Hospital, an Ambulatory Surgical Facility, or the Physician's office). If the Plan determines that your treatment does not require Inpatient care, you and your Provider will be notified of that decision. **If you proceed with an Inpatient stay without the Plan's approval, or if you do not ask the Plan for Precertification, your Benefits under this Certificate will be reduced by $**[0–1,000] **for that admission, provided the Plan determines that Benefits are payable upon receipt of a claim.** [This reduction applies in addition to any Benefit reduction associated with your use of an Out–of–Network Provider.]

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

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

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

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

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

- **Precertification Requests Involving Urgent Care**

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

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

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

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

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

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

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

- **Precertification Requests Involving Emergency Care**

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

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

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

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

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

Concurrent Review and Case Management

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

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

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

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

[Referral Care

Your BlueChoice PPO Provider has the responsibility of sending you to other Providers within the BlueChoice PPO Provider network as his or her first choice for referrals. In certain cases, however, it may be the opinion of your BlueChoice PPO Provider that you require specialized treatment or consultation that cannot be received from a Provider within the BlueChoice PPO Provider network. In those instances, your BlueChoice PPO Provider will refer you to a specialty, Out–of–Network Provider.

To be sure that you receive the maximum Benefits available under this program, you should always check your BlueChoice PPO Provider directory before you seek care from another Provider. If the Provider is not listed in the directory, you should ask your BlueChoice PPO Provider to request Referral Care approval from Blue Cross and Blue Shield of Oklahoma on your behalf. If this request is approved, you and your BlueChoice Provider will receive an approval letter in the mail. After getting Referral Care approval, you may receive care or services from a specialty, Out–of–Network Provider for that episode of treatment without the additional out–of–pocket expenses usually associated with using Out–of–Network Providers.

Your approved Referral Care may be subject to a specified period of time or a particular service. Be sure to check with Blue Cross and Blue Shield of Oklahoma to learn exactly which services and time period are approved.]

[Prescription Drug Precertification Process

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

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

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

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

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

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

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

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

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

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

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

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

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

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

  — If Precertification is approved for the drug, you may return to the Pharmacy to obtain the full Prescription Order, subject to any Deductible and/or Coinsurance amount applicable to the balance of the drug quantity dispensed.

  — If the Precertification is denied, you may obtain your Prescription Order by paying the full cost for the drugs.

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

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

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

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

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

Allowable Charge

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

- [BluePreferred and BlueCard PPO][BlueChoice PPO and BlueCard PPO][BluePreferred, BlueChoice, BlueTraditional and BlueCard PPO][BlueTraditional and BlueCard] Providers have agreed to hold the line on health care costs by providing special prices for our Subscribers. These Providers will accept this negotiated price (called the **"Allowable Charge"**) as payment for Covered Services. This means that, if a network Provider bills you more than the Allowable Charge for Covered Services, ***you are not responsible for the difference.***

- Blue Cross and Blue Shield of Oklahoma will calculate your Benefits based on this "Allowable Charge". We will deduct any charges for services which aren't eligible under your coverage, then subtract your [Copayment,] Deductible and/or Coinsurance amounts which may be applicable to your Covered Services. We will then determine your Benefits under this Certificate, and direct any payment to your network Provider.

REMEMBER ...

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

Your coverage contains special provisions (Benefit reductions) which apply whenever you use Out–of–Network Providers. If you use an Out–of–Network Provider, your Benefits will be determined as follows:

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

  — Charges for any services which are not covered under your Group Health Plan.

  — Any Deductible or Coinsurance amounts that are applicable to your coverage *(including the higher Coinsurance amounts which apply to Out–of–Network Provider services)*.

  — The difference, if any, between your Provider's "billed charges" and the "Allowable Charge" which a [BluePreferred][BlueChoice PPO][BlueTraditional]Provider would have accepted for the same services.

- 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, and the claim for those services is filed with the Blue Cross and Blue Shield Plan (Host Plan) servicing the area, the "Allowable Charge" will be determined by the Host Plan. This Allowable Charge will be the amount the Host Plan uses for their own local members that obtain services from local non–contracting Providers. You will be responsible for the following:

  — Charges for any services which are not covered under your Group Health Plan.

  — Any Deductible or Coinsurance amounts that are applicable to your coverage *(including the higher Coinsurance amounts which apply to Out–of–Network Provider services)*.

  — The difference, if any, between your Provider's "billed charges" and the "Allowable Charge" determined by the Host Plan.

- In instances where the claim is not filed with the Host Plan, the Allowable Charge for your out–of–network claims will be ***based upon what the Plan would have reimbursed a [BluePreferred][BlueChoice PPO] [BlueTraditional] Provider for the same service.*** You will be responsible for the following:

  — Charges for any services which are not covered under your Group Health Plan.

  — Any Deductible or Coinsurance amounts that are applicable to your coverage (*including the higher Coinsurance amounts which apply to Out–of–Network Provider services*).

  — The difference, if any, between your Provider's "billed charges" and the "Allowable Charge" which a Provider would have accepted for the same services.

- [In certain instances, your services may be rendered by a Provider who has a Participating Provider Agreement (other than a [BlueChoice PPO] [BluePreferred]Participating Agreement) with Blue Cross and Blue Shield of

Oklahoma. These Providers (called BlueTraditional Providers) have agreed to charge Plan Subscribers no more than a "Maximum Reimbursement Allowance" for Covered Services. If you receive Covered Services from a BlueTraditional Provider, you will be responsible for the following:

— Charges for any services which are not covered under your Group Health Plan.

— Any Deductible or Coinsurance amounts that are applicable to your coverage (*including the higher Coinsurance amounts which apply to Out–of–Network Provider services*).

— Any amounts over the "Allowable Charge" up to be not exceeding the "Maximum Reimbursement Allowance" specified in their Participating Provider Agreement.]

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

Special Notices

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

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

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

Identification Card

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

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

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

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

Designating an Authorized Representative

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

Questions

Whenever you call our 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 Certificate. If you need more help, please call a Customer Service Representative at [1–800–94 BLUES (1–800–942–5837)].

Or you can write:

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

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

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

[For questions regarding your dental Benefits, please call [1–888–381–9727]. Or, you can write:

[Blue Cross and Blue Shield of Oklahoma
c/o Dental Network of America, Inc.
P.O. Box 23100
Belleville, Illinois 62223–0100]]

Eligibility, Enrollment, Changes & Termination

This section tells:

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

Who Is an Eligible Person

[Unless otherwise specified in the Group Contract, you are an Eligible Person if you are an Employee who works on a full–time basis with a normal work week of 24 or more hours. If you work on a part–time, temporary or substitute basis, you are not considered an Eligible Person.]

[Unless otherwise specified in the Group Contract, you are an Eligible Person if you are an Employee who works on a full–time basis with a normal work week of [20–50] or more hours. If you work on a part–time, temporary or substitute basis, you are not considered an Eligible Person.]

[This Certificate contains information about the health care benefit program for the persons in your Group who:

- [Meet the definition of an Eligible Person as specified in the Group Contract.]
- [Meet the following definition of an Eligible Person: A full–time Employee of the Group. A full–time Employee is a person who is scheduled to work a minimum of [20–50] hours per week and who is on the permanent payroll of the Group.]
- [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 program.]

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

Who Is an Eligible Dependent

An Eligible Dependent is defined as:

- your spouse.
- [your Domestic Partner.]

- your unmarried child, including a newborn child, adopted child, stepchild, or other child for whom you or your spouse is legally responsible.

  — Unmarried Dependent children [under age [19–30]] are eligible for coverage until [the end of the month following] [January 1 of the year following] their [19th–30th] birthday.

  — [Unmarried Dependent children who are enrolled as Full–Time Students are eligible for coverage until their [19th–30th] birthday.]

  — Unmarried Dependent children who are medically certified as disabled and dependent upon you or your spouse are eligible for coverage regardless of age.

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

How to Enroll

To Enroll in this health care program, you must complete an application form provided by the Plan, including all information needed to determine eligibility. Your membership may include:

- [Member Only (Single)][Member–Only][Single] Coverage — if only you Enroll.
- [Member and Spouse Only Coverage — for you and your spouse.]
- [Member and Children Coverage — for you and your Dependent children.]
- [Member, Spouse and Children Coverage (Family Coverage)] [Member, Spouse and Children Coverage][Family Coverage] — for you and all of your Eligible Dependents.

IMPORTANT:

In order to assure your application is processed and your coverage is effective at the earliest possible date, you must Enroll during your first period of eligibility (designated by your Group).

Initial Enrollment Period

- **Initial Group Enrollment**

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

- **Initial Enrollment After the Group's Contract Date**

  If you become an Eligible Person after the Group's Contract Date and your application is received by the Plan within [31–90] days of being first eligible, the Effective Date for you and your Eligible Dependents (if applicable) will be assigned by the Plan, according to the provisions of the Contract in effect for your Group.

- **Initial Enrollment of New Dependents**

  You can apply to add Dependents to your coverage if we receive your [“Request for Change in Membership” form] [change form] [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 Certificate, then the following rules apply:

- If you are enrolled under [Member Only (Single)][Member–Only][Single] Coverage, you may add coverage for a newborn effective on the date of birth. However, your [“Request for Change in Membership” form] [change form] [application] must be received by the Plan within [31–90] days of the child’s birth.

- [If you are enrolled under Member 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 [“Request for Change in Membership” form] [change form] [application] must be received by the Plan within 31 days of the child’s birth.]

- If you are enrolled under [Member and Children Coverage,] [Member, 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 (please submit your [“Request for Change in Membership” form] [change form] [application] within [31–90] 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 Certificate) 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 the Plan receives your [“Request for Change in Membership” form] [change form] [application] (including your child’s name and birth date) within [31–90] 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 [“Request for Change in Membership” form] [change form] [application] is received by the Plan within [31–90] days of the date the child is placed in your custody. The Effective Date for the child will be the date you assumed the physical custody of the adopted child and the financial responsibility for the support and care of the adopted child. A copy of the court order or adoption papers must be submitted to the Plan with the change form.

Subject to the Exclusions, conditions and limitations of this Certificate, coverage for an adopted child 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

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

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

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

  — You and/or your Dependent must otherwise be eligible for coverage under the terms of the Group Health 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 Contract:

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

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

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

  — Your application for special enrollment must be received by the Plan within [31–90] 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 to Enroll or your ["Request for Change in Membership" form] [change form] (if you are already enrolled) must be received by the Plan within [31–90] 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 Member's application to add the Dependent is received by the Plan within [31–90] days after issuance of a court order requiring coverage be provided for a spouse or minor or Dependent child under the Member's coverage. The Effective Date will be determined by the Plan in accordance with the provisions of the court order.

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 at any time. However, coverage will be delayed until the Group's next Contract Date Anniversary. In order to verify your coverage election, you and/or your Dependent(s) will be asked to "reapply" for coverage during the Group's Open Enrollment Period. An Open Enrollment Period will be held each year during the [30–60]–day period immediately before the Group's Contract Date Anniversary (renewal date). Your application for coverage must be received by the Plan within this time period.

Individuals who Enroll during an Open Enrollment Period will be considered Late Enrollees under the Contract and will be subject to an 18–month Preexisting Condition Exclusion period. However, the 18–month Preexisting Condition Exclusion period will be reduced by the following:

- the days of prior Creditable Coverage in effect before your and/or your Dependent's application was received by the Plan; and

- the period of time between the Contract Date Anniversary and the date your and/or your Dependent's initial application for coverage was received by the Plan (for individuals who applied for coverage prior to the Open Enrollment 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[Copayment,] Deductible 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 [1–800–94 BLUES (1–800–942–5837)].

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 Contract Date; or
- [covered under BlueLincs HMO coverage (if applicable) and you transfer coverage to this Certificate:
  - during the Annual Transfer Period; or
  - within [31–90] days of the date you move your residence outside the BlueLincs HMO service area.]

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 eligibility ceases.

[Transfers From Alternate Coverage Options

Some Groups offer coverage through an alternate program provided by Blue Cross and Blue Shield of Oklahoma[, and/or through BlueLincs HMO, a subsidiary of Health Care Service Corporation]. Check with your Group Administrator to see what coverage options are available to you.

If your Group does offer coverage options other than this health care program, there are certain periods during which you can transfer coverage from one program to another:

- An Annual Transfer Period will be held each year during the [30–60]–day period immediately before your Group's Contract Date Anniversary (see your Group Administrator for specific dates). During this period, you may transfer your coverage to this program if you are currently enrolled under your Employer's alternate Plan Group Contract[or BlueLincs HMO]. Your Effective Date will coincide with your Group's Contract Date Anniversary.

- [If you have coverage through BlueLincs HMO and you move outside the BlueLincs HMO service area, you may also apply for coverage under this Certificate. Be sure your application is received by the Plan within 31 days of the date you move your residence outside the BlueLincs HMO service area].

Your Effective Date will be the first billing cycle coinciding with or next following the date your application is approved by the Plan.]

[When Eligibility Continues

- [TOTAL DISABILITY

  If you, the Eligible Person, become Totally Disabled, your eligibility under this Certificate will continue for a period which shall be the lesser of:

  — six months following the date you become disabled; or

  — the uninterrupted duration of your Total Disability.]

- [OTHER

  Check with your Group Administrator for eligibility provisions unique to your Group's coverage.]]

COBRA Continuation Coverage

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

- **Eligibility for Continuation Coverage**

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

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

  — your divorce or legal separation; or

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

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

- **Election of Continuation Coverage**

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

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

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

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

- **COBRA Continuation Coverage Period**

  You and/or your Eligible Dependents are eligible for coverage to continue under your Group's coverage for a period not to exceed:

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

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

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

    ○ the ineligibility of a Dependent child;

  provided the premiums are paid for the coverage as required.

- **Disability Extension**

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

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

- **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 Certificate Ends

When a Subscriber is no longer an Eligible Person or Eligible Dependent, coverage stops at the end of the coverage period during which eligibility ceases, except in the following cases:

- In the case of an Employee whose coverage is terminated, such Employee and his/her Dependents shall remain insured under the Contract for a period of 31 days after such termination, unless during such period the Employee and his/her Dependents shall otherwise become entitled to similar insurance from some other source.

- When a Subscriber ceases to be an Eligible Dependent by reason of death, coverage for that Subscriber will cease on the date of death.
- A Subscriber's COBRA Continuation Coverage, when applicable, will cease on 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 Subscriber is no longer disabled (when coverage has been extended from 18 months to 29 months due to disability);
  - — the date on which the Group stops providing any Group Health Plan to any Employee;
  - — the date on which coverage stops because of a Subscriber's failure to pay to the Group any premiums required for the COBRA Continuation Coverage;
  - — the date on which the Subscriber 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 Subscriber (or the date the Subscriber has satisfied the Preexisting Condition Exclusion period under that plan); or
  - — the date on which the Subscriber becomes (after the date of the election) entitled to benefits under Medicare.

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

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

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

What We Will Pay for After Your Coverage Ends

- If your coverage ends for any reason, your Benefits will end on the effective date and time of such termination. However, termination will not deprive you of Benefits to which you would otherwise be entitled for Covered Services Incurred during a Hospital confinement which began before the date and time of termination. Benefits will be provided only for the lesser of:
  - — a period of time equal to the length of time you were covered under the Contract; or
  - — the duration of the Hospital confinement; or
  - — 90 days following termination of coverage; or
  - — the date the Subscriber becomes entitled to similar insurance through some other source.
- If your coverage ends because the Member terminates employment, or because the Group itself is terminated, your Benefits will end on the effective date and time of the termination of coverage. However, if you were covered under the Group Contract for at least six months before your coverage terminates, then you will be eligible for an extension of Benefits under this Certificate if:
  - — Covered Services are Incurred due to illness or injury because of which you are Totally Disabled at the date and time such coverage is terminated; or

— you have not completed a plan of surgical treatment (including maternity care and delivery expenses) which began prior to the date and time of such termination.

Coverage for the extension of Benefits will be limited to the lesser of:

— the uninterrupted duration of the Total Disability or completion of a plan of surgical treatment; or

— the payment of maximum Benefits; or

— six months following the date and time your coverage terminates.

Your premiums must be submitted to us during the period of the extension of Benefits and will be the same premiums which would have been charged for the coverage under the Group Contract had termination not occurred.

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

Conversion Privilege After Termination of Group Coverage

If you stop being a Subscriber under the Group Contract, you are eligible for coverage under our Individual Conversion contract.

If you move to an area serviced by another Blue Cross Plan, you may transfer to the Blue Cross Plan serving that area.

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

Payment for coverage under the conversion contract must be made from the date you cease to be a Subscriber under this Certificate.

Written application for a conversion contract must be received by Blue Cross and Blue Shield of Oklahoma no later than 31 days after your coverage terminates under this Certificate.

A conversion contract will not be available if you are:

- a Member who is eligible for coverage under a group having a contract with us; or
- a Dependent who is covered under any policy of benefits for hospital and surgical/medical care and services provided by an employer or group; or
- any Subscriber who ceases to be eligible due to cancellation of the Contract, unless approved by the Plan.

[When You Turn Age 65

Plan coverage is available to you and/or your spouse over age 65. However, the type of coverage you receive will depend upon whether you continue to work and the rules in effect for your particular Group, including federal regulations which apply to working people age 65 and older.

Your coverage may include:

- a continuation of Group Benefits;
- a combination of Group Benefits and Medicare; or
- one of our Medicare Supplement Policies.

Check with your Group Administrator for details regarding the coverage options available to you and your Dependents (if any).]

[When You Retire

When you retire at or after age 65 and have applied for Medicare, you may apply for our Medicare supplement coverage within 31 days of the day you retire.

If you retire before your 65th birthday, you may convert to an Individual Conversion contract within 31 days of your retirement date. Then when you become age 65, you may apply for our Medicare supplement coverage. Check with your Group Administrator for more information.

NOTE: Some Groups have special eligibility provisions regarding retired Employees. **Check with your Group Administrator for retiree eligibility provisions unique to your Group's coverage.**]

[**IMPORTANT:**

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

Certificates of Coverage

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

- **Qualified Beneficiaries Upon a Qualifying Event**

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

- **Other Individuals When Coverage Ceases**

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

- **Qualified Beneficiaries When COBRA Ceases**

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

- **Any Individual Upon Request**

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

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

Blue Cross and Blue Shield of Oklahoma has established a toll−free telephone number [(1−888−250−2005)] to assist Subscribers in obtaining Certificates of Coverage and Preexisting Condition “credit”.

Schedule of Benefits
Comprehensive Health Care Services

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

BENEFIT PERIOD	[Calendar Year] [Contract Year]
[**OFFICE VISIT COPAYMENT**	[$[0–100] for each visit to a BlueChoice PPO Physician's office.] [The amount specified in the insert in the front of this Certificate.]The Copayment applies to charges which are billed as part of your Physician's office visit. **EXCEPTION**: The office visit Copayment does not apply to the following services, which (except for covered childhood immunizations) are subject to the Deductible and Coinsurance provisions of your coverage): • [Surgical services.] • [[Speech Therapy,]Physical Therapy and Occupational Therapy.] • [Chemotherapy.] • [Allergy testing and allergy injections.] • Covered childhood immunizations[(for Subscribers under age [19–25])]. • [Psychiatric Care Services.] • [Prescription Drugs.] • [Durable Medical Equipment.]

[The Copayment will also apply to laboratory and x–ray services performed at a BlueChoice PPO Provider in conjunction with a covered office visit, except for:

- Magnetic resonance imaging (MRI), computed tomography (CT), positron emission tomography (PET), electroencephalogram (EEG), echocardiogram, myocardial perfusion studies (MPS), and other similar imaging tests; and
- Pathology and laboratory procedures under the CPT code classifications of Cytogenetic Studies, Surgical Pathology, or Transcutaneous Procedures.]

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

DEDUCTIBLE

[Out–of–Network Hospital Deductible

[$[100–5,000] per Inpatient Hospital Admission.][The amount specified in the insert in the front of this Certificate.]

This Deductible applies to all Covered Services Incurred during your admission to a Hospital which is not a BlueChoice PPO Provider[, except for:

- Routine Nursery Care;
- Plan–approved Referral Care;
- Emergency Care.]]

[Hospital Admission Deductible

[$[100–5,000] for each visit to a Hospital.] [The amount specified in the insert in the front of this Certificate.]This Deductible applies to all Covered Services Incurred during the Subscriber's admission to a Hospital[, except Routine Nursery Care.]]

[Emergency Room Deductible

[$[50–1,000] for each visit to a Hospital emergency room.] [The amount specified in the insert in the front of this Certificate.][This Deductible is waived if the Subscriber is admitted to the Hospital through the emergency room visit.]]

[Outpatient Surgery Deductible

[$[100–5,000] for each visit to an Outpatient facility for Surgery.] [The amount specified in the insert in the front of this Certificate.]This Deductible applies to surgical procedures received in a Hospital Outpatient department or Ambulatory Surgical Facility.]

[Benefit Period Deductible

[$[100–10,000] per Benefit Period per Subscriber.] [The amount specified in the insert in the front of this Certificate.]The Benefit Period Deductible is in addition to any other Deductible described above.]

[BlueChoice Provider Services Deductible	[$[100–10,000] per Benefit Period per Subscriber.][The amount specified in the insert in the front of this Certificate.] This Deductible applies to Covered Services received from a BlueChoice PPO Provider. If the Subscriber has Incurred expenses which were applied toward his or her Out–of–Network Provider Services Deductible during the Benefit Period, those expenses will also count toward satisfaction of his or her Deductible amount for BlueChoice PPO Provider Services.]
[Out–of–Network Provider Services Deductible	[$[100–10,000] per Benefit Period per Subscriber.][The amount specified in the insert in the front of this Certificate.] This Deductible applies whenever the Subscriber receives Covered Services from a Provider who is not a member of the BlueChoice PPO Provider Network. If the Subscriber has Incurred expenses which were applied toward his or her BlueChoice PPO Provider Services Deductible during the Benefit Period, those expenses will also count toward satisfaction of his or her Deductible amount for Out–of–Network Provider Services.]
Covered Services ***Not*** Subject to Benefit Period Deductible	The Benefit Period Deductible applies to all Covered Services, except: • [Accidental Injury Services (Deductible will apply after eligible charges exceed $[100–5,000] for all Accidental Injury Services during the Benefit Period).] • [Routine Nursery Care.] • [Preventive Care Services][for Subscribers age [16–25] or older] [(limited to $[100–5,000] per Benefit Period)].] • [Annual routine gynecological/obstetrical examination and Pap smear.] • Annual prostate cancer screening [(limited to $[65–200] per screening)]. • Covered childhood immunizations [for Subscribers under age [19–25])]. • Routine Low–Dose Mammography [(limited to $[115–500] per screening)]. • [BlueChoice PPO Physician services which are subject to the office visit Copayment.] • [Ambulance Services.]]
[Deductible Carryover	Expenses Incurred for Covered Services in the last three months of a Benefit Period which were applied to that Benefit Period's Deductible will be applied to the Deductible of the next Benefit Period.]

[Deductible Credit

If your Group changed carriers during your benefit period, expenses you Incurred and which were applied toward your Deductible during the last partial benefit period for services covered by the prior carrier will be applied to the Deductible of your initial Benefit Period under this Certificate.]

[**FAMILY DEDUCTIBLE**

[If your coverage includes your Dependents, then:

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

[If your coverage includes your Dependents, then no more than [two–three] Subscribers covered under that membership must satisfy their Deductibles in one Benefit Period.]

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

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

[**STOP-LOSS LIMIT**

- [**BlueChoice PPO and BlueCard PPO Provider Services** — When you have Incurred [$[1,000–100,000]][the amount specified in the insert in the front of this Certificate] (in excess of any [Copayment and/or]Deductible amounts) for Covered Services provided by BlueChoice PPO and BlueCard PPO Providers during a Benefit Period, the amount of Allowable Charges covered by the Plan on your behalf will increase to 100% during the remainder of the Benefit Period for Covered Services you receive from network Providers.]
- [**Out–of–Network Provider Services** — When you have Incurred [$[1,000–100,000]][the amount specified in the insert in the front of this Certificate] (in excess of any [Copayment and/or] Deductible amounts) for Covered Services provided by Out–of–Network Providers during a Benefit Period, the amount of Allowable Charges covered by the Plan on your behalf will increase to 100% during the remainder of the Benefit Period for Out–of–Network Provider services.]]

[When you have Incurred [$[1,000–100,000]][the amount specified in the insert in the front of this Certificate] (in excess of any [Copayment and/or]Deductible amounts) for Covered Services during a Benefit Period, the amount of Allowable Charges covered by the Plan on your behalf will increase to 100% during the remainder of the Benefit Period.]

[The Stop–Loss Limits and Benefit percentage amount specified above do not apply to expenses Incurred for[:]

- [Psychiatric Care Services [(except for treatment of Severe Mental Illness)].]
- [BlueChoice PPO Physician services which are subject to the office visit Copayment.]
- [Outpatient Prescription Drugs.]
- charges in excess of the Allowable Charge.]]

[**FAMILY STOP-LOSS LIMIT**

- [**BlueChoice PPO and BlueCard PPO Provider Services** — When you and your Dependents have Incurred [$[1,000–100,000]][the amount specified in the insert in the front of this Certificate] (in excess of any [Copayment and/or]Deductible amounts) for Covered Services provided by BlueChoice PPO and BlueCard PPO Providers during a Benefit Period, the amount of Allowable Charges covered by the Plan on behalf of all covered family members will increase to 100% during the remainder of the Benefit Period for Covered Services you receive from network Providers.]
- [**Out–of–Network Provider Services** — When you and your Dependents have Incurred [$[1,000–100,000]][the amount specified in the insert in the front of this Certificate] (in excess of any [Copayment and/or]Deductible amounts) for Covered Services provided by Out–of–Network Providers during a Benefit Period, the amount of Allowable Charges covered by the Plan on behalf of all covered family members will increase to 100% during the remainder of the Benefit Period for Out–of–Network Provider services.]

[These Stop–Loss Limits are cumulative. This means that any expenses you receive from BlueChoice PPO Providers, BlueCard PPO Providers or Out–of–Network Providers will count toward the Stop–Loss Limits for both in–network and out–of–network services. However, the Out–of–Network Provider Services Stop–Loss Limit will apply any time you receive services from an Out–of–Network Provider, even though you may have previously satisfied the in–network Stop–Loss Limit.]

[When you and your Dependents have Incurred[$[1,000–100,000][the amount specified in the insert in the front of this Certificate] (in excess of any [Copayment and/or]Deductible amounts) for Covered Services provided by BlueChoice PPO, BlueCard PPO or Out–of–Network Providers during a Benefit Period, the amount of Allowable Charges covered by the Plan on behalf of all covered family members will increase to 100% during the remainder of the Benefit Period.]

[**OUT-OF-POCKET LIMIT**

- [**BlueChoice PPO and BlueCard PPO Provider Services** — When you have paid $[1,000–100,000][the amount specified in the insert in the front of this Certificate](in excess of any [Copayment and/or]Deductible amounts) for Covered Services provided by BlueChoice PPO and BlueCard PPO Providers during a Benefit Period, the amount of Allowable Charges covered by the Plan on your behalf will increase to 100% during the remainder of the Benefit Period for Covered Services you receive from network Providers.]

- [**Out–of–Network Provider Services** — When you have paid $[1,000–100,000][the amount specified in the insert in the front of this Certificate](in excess of any [Copayment and/or]Deductible amounts) for Covered Services provided by Out–of–Network Providers during a Benefit Period, the amount of Allowable Charges covered by the Plan on your behalf will increase to 100% during the remainder of the Benefit Period for Out–of–Network Provider services.]

[When you have paid [$[1,000–100,000][the amount specified in the insert in the front of this Certificate](in excess of any [Copayment and/or]Deductible amounts) for Covered Services during a Benefit Period, the amount of Allowable Charges covered by the Plan on your behalf will increase to 100% during the remainder of the Benefit Period.]

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

- [Psychiatric Care Services [(except for treatment of Severe Mental Illness)].]

- [BlueChoice PPO Physician services which are subject to the office visit Copayment.]

- [Outpatient Prescription Drugs.]

- charges in excess of the Allowable Charge.]]

[**FAMILY OUT-OF-POCKET LIMIT**

- [**BlueChoice PPO and BlueCard PPO Provider Services –** When you and your Dependents have paid [$[1,000–100,000]][the amount specified in the insert in the front of this Certificate] (in excess of any [Copayment and/or]Deductible amounts) for Covered Services provided by BlueChoice PPO and BlueCard PPO Providers during a Benefit Period, the amount of Allowable Charges covered by the Plan on behalf of you and your Dependents will increase to 100% during the remainder of the Benefit Period for Covered Services received from network Providers.]

- [**Out–of–Network Provider Services** – When you and your Dependents have paid [$[1,000–100,000]][the amount specified in the insert in the front of this Certificate] (in excess of any [Copayment and/or]Deductible amounts) for Covered Services provided by Out–of–Network Providers during a Benefit Period, the amount of Allowable Charges covered by the Plan on behalf of you and your Dependents will increase to 100% during the remainder of the Benefit Period for Out–of–Network Provider services.]

[When you and your Dependents have paid [$[1,000–100,000][the amount specified in the insert in the front of this Certificate] (in excess of any [Copayment and/or]Deductible amounts) for Covered Services provided by BlueChoice PPO, BlueCard PPO or Out–of–Network Providers during a Benefit Period, the amount of Allowable Charges covered by the Plan on behalf of all covered family members will increase to 100% during the remainder of the Benefit Period.]

MAXIMUM

$[250,000–10,000,000] per lifetime per Subscriber, including any other limitations specifically stated in this Certificate.] [Unlimited]

BENEFIT PERCENTAGE AMOUNT

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

[The percentages shown for "Out–of–Network Provider Services" apply whenever you receive care from a Provider who is not a BlueChoice PPO or BlueCard PPO Provider. However, this reduction in Benefits will not apply to the following Covered Services, which are paid at the same percentage amount of the Allowable Charge applicable to Covered Services received from a BlueChoice PPO or BlueCard PPO Provider:

- Plan–approved Referral Care;
- Emergency Care;
- [Accidental Injury Services (Deductible will apply after eligible charges exceed $[100–5,000] for all Accidental Injury Services during the Benefit Period);]
- Hospital Services received as an Inpatient;
- Covered Services rendered by a Provider whose specialty is not represented within the BlueChoice PPO or BlueCard PPO Provider network (as determined by the Plan).]

COVERED SERVICES (Subject to the *Comprehensive Health Care Services* section which follows)	BENEFIT PERCENTAGE AMOUNT: BlueChoice PPO & BlueCard PPO Provider Services	Out–of–Network Provider Services
[**ACCIDENTAL INJURY SERVICES** [(Limited to $[100–5,000] per Benefit Period)]	[50–100]%	[50–100]%]
HOSPITAL SERVICES	[50–100]%	[50–100]%
SURGICAL/MEDICAL SERVICES		
Physicians' Office Visits		
[Preventive Care Services [(Limited to $[100–5,000] per Benefit Period] [for Subscribers age [16–25] or older)]	[50–100]%	[50–100]%]
Annual Routine Gynecological/ Obstetrical Examination and Pap Smear	[50–100]%	[50–100]%
Covered Childhood Immunizations [(Limited to Subscribers under age [19–25])]	[100]%	[100]%
[Other Physicians' Office Visits	[50–100]%*	[50–100]%]
All Other Covered Surgical/Medical Services	[50–100]%	[50–100]%
OUTPATIENT DIAGNOSTIC SERVICES		
Routine Low–Dose Mammography [(Limited to $[115–500] per screening)]	[100]%	[100]%
All Other Covered Diagnostic Services	[50–100]%	[50–100]%
OUTPATIENT THERAPY SERVICES	[50–100]%	[50–100]%
MATERNITY SERVICES	[50–100]%	[50–100]%
MASTECTOMY AND RECONSTRUCTIVE SURGICAL SERVICES	[50–100]%	[50–100]%
HUMAN ORGAN, TISSUE AND BONE MARROW TRANSPLANT SERVICES	[50–100]%	[50–100]%
AMBULATORY SURGICAL FACILITY SERVICES	[50–100]%	[50–100]%

**Applicable only to Covered Services which are subject to the office visit Copayment. For services which are not subject to the office visit Copayment , this percentage amount is reduced to [50–100]% of Allowable Charges after satisfaction of the Deductible.*

COVERED SERVICES (Subject to the *Comprehensive Health Care Services* section which follows)	BENEFIT PERCENTAGE AMOUNT: BlueChoice PPO & BlueCard PPO Provider Services	Out–of–Network Provider Services
[PSYCHIATRIC CARE SERVICES	[50–100]%	[50–100]%]
[PSYCHIATRIC CARE SERVICES	[50–100]%	[50–100]%]
Covered Services for Treatment of Severe Mental Illness	[50–100]%	[50–100]%
All Other Covered Psychiatric Care Services	[50–100]%	[50–100]%]
AMBULANCE SERVICES	[50–100]%	[50–100]%
PRIVATE DUTY NURSING SERVICES	[50–100]%	[50–100]%
REHABILITATION CARE	[50–100]%	[50–100]%
SKILLED NURSING FACILITY SERVICES	[50–100]%	[50–100]%
HOME HEALTH CARE SERVICES	[50–100]%	[50–100]%
HOSPICE SERVICES	[50–100]%	[50–100]%
[OUTPATIENT PRESCRIPTION DRUGS AND RELATED SERVICES	[50–100]%*	[50–100]%]
ALL OTHER COVERED SERVICES	[50–100]%	[50–100]%

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

Schedule of Benefits
Comprehensive Health Care Services

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

BENEFIT PERIOD

[Calendar Year][Contract Year]

[**OFFICE VISIT COPAYMENT**

[$[0–100] for each visit to a BluePreferred Physician's office.] [The amount specified in the insert in the front of this Certificate.]The Copayment applies to charges which are billed as part of your BluePreferred Physician's office visit.

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

- [Surgical services.]
- [[Speech Therapy,]Physical Therapy and Occupational Therapy.]
- [Chemotherapy.]
- [Allergy testing and allergy injections.]
- Covered childhood immunizations[(for Subscribers under age [19–25]).
- [Psychiatric Care Services.]
- [Prescription Drugs.]
- [Durable Medical Equipment.]

[The Copayment will also apply to laboratory and x–ray services performed at a BluePreferred Provider in conjunction with a covered office visit, except for:

- Magnetic resonance imaging (MRI), computed tomography (CT), positron emission tomography (PET), electroencephalogram (EEG), echocardiogram, myocardial perfusion studies (MPS), and other similar imaging tests; and
- Pathology and laboratory procedures under the CPT code classifications of Cytogenetic Studies, Surgical Pathology, or Transcutaneous Procedures.]

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

DEDUCTIBLE

[Out–of–Network Hospital Deductible	[$[100–5,000] per Inpatient Hospital Admission.][The amount specified in the insert in the front of this Certificate.] This Deductible applies to all Covered Services Incurred during the Subscriber's admission to a Hospital which is not a BluePreferred Provider.]
[Hospital Admission Deductible	[$[100–5,000] for each visit to a Hospital]. [The amount specified in the insert in the front of this Certificate.] This Deductible applies to all Covered Services Incurred during the Subscriber's admission to a Hospital[, except Routine Nursery Care.]
[Emergency Room Deductible	[$[50–1,000] for each visit to a Hospital emergency room.] [The amount specified in the insert in the front of this Certificate.][This Deductible is waived if the Subscriber is admitted to the Hospital through the emergency room visit.]]
[Outpatient Surgery Deductible	[$[100–5,000] for each visit to an Outpatient facility for Surgery.] [The amount specified in the insert in the front of this Certificate.]This Deductible applies to surgical procedures received in a Hospital Outpatient department or Ambulatory Surgical Facility.]
[BluePreferred Provider Services Deductible	[$[100–10,000] per Benefit Period per Subscriber.] [The amount specified in the insert in the front of this Certificate.] [This Deductible applies to Covered Services received from a BluePreferred Provider.] [If the Subscriber has Incurred expenses which were applied toward his or her Out–of–Network Provider Services Deductible during the Benefit Period, those expenses will also count toward satisfaction of his or her Deductible amount for BluePreferred Provider Services.]]
[Out–of–Network Provider Services Deductible	[$[100–10,000] per Benefit Period per Subscriber.][The amount specified in the insert in the front of this Certificate.] This Deductible applies whenever the Subscriber receives Covered Services from a Provider who is not a member of the BluePreferred Provider Network. [If the Subscriber has Incurred expenses which were applied toward his or her BluePreferred Provider Services Deductible during the Benefit Period, those expenses will also count toward satisfaction of his or her Deductible amount for Out–of–Network Provider Services.]]

Covered Services ***Not*** Subject To Benefit Period Deductible

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

- [Accidental Injury Services (Deductible will apply after eligible charges exceed $[100–5,000] for all Accidental Injury Service during the Benefit Period).]
- [Routine Nursery Care ($[100–5,000] Out–of–Network Hospital Deductible ***does*** apply).]
- [Preventive Care Services] [for Subscribers age [16–25] or older] [(limited to $[100–5,000] per Benefit Period)].]
- Annual prostate cancer screening [(limited to $[65–200] per screening)].
- [Annual routine gynecological/obstetrical examination and Pap smear.]
- Covered childhood immunizations [(for Subscribers under age [19–25])].
- Routine Low–Dose Mammography [(limited to $[115–500] per screening)].
- [BluePreferred Physician services which are subject to the office visit Copayment.]
- [Ambulance Services.]

[Deductible Carryover

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

[Deductible Credit

If your Group changed carriers during your benefit period, expenses you Incurred and which were applied toward your Deductible during the last partial benefit period for services covered by the prior carrier will be applied to the Deductible of your initial Benefit Period under this Certificate.]

[**FAMILY DEDUCTIBLE**

[If your coverage includes your Dependents, then:

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

[If your coverage includes your Dependents, then no more than [two–three] Subscribers covered under that membership must satisfy their Deductibles in one Benefit Period.]

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

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

[**STOP-LOSS LIMIT**

- [**BluePreferred and BlueCard PPO Provider Services** — When you have Incurred [$[1,000–100,000]] [the amount specified in the insert in the front of this Certificate] (in excess of any [Copayment and/or]Deductible amounts) for Covered Services provided by BluePreferred and BlueCard PPO Providers during a Benefit Period, the amount of Allowable Charges covered by the Plan on your behalf will increase to 100% during the remainder of the Benefit Period for Covered Services you receive from Network Providers.]

- [**Out–of–Network Provider Services** — When you have Incurred [$[1,000–100,000]] [the amount specified in the insert in the front of this Certificate] (in excess of any [Copayment and/or]Deductible amounts) for Covered Services provided by Out–of–Network Providers during a Benefit Period, the amount of Allowable Charges covered by the Plan on your behalf will increase to 100% during the remainder of the Benefit Period for Out–of–Network Provider services.]

[These Stop–Loss Limits are cumulative. This means that any expenses you receive from BluePreferred Providers, BlueCard PPO Providers or Out–of–Network Providers will count toward the Stop–Loss Limits for both in–network and Out–of–Network services. However, the Out–of–Network Provider Services Stop–Loss Limit will apply any time you receive services from an Out–of–Network Provider, even though you may have previously satisfied the Stop–Loss Limit for network Provider services.]

[When you have Incurred [$[1,000–100,000]] [the amount specified in the insert in the front of this Certificate](in excess of any [Copayment and/or] Deductible amounts) for Covered Services during a Benefit Period, the amount of Allowable Charges covered by the Plan on your behalf will increase to 100% during the remainder of the Benefit Period.]

[Separate Stop–Loss Limits apply to BluePreferred Provider Services and Out–of–Network Provider Services (as specified in the insert in the front of this Certificate).]

[The Stop–Loss Limits and Benefit percentage amount specified above do not apply to expenses Incurred for[:]

- [Psychiatric Care Services[(except for treatment of Severe Mental Illness)].]
- [BluePreferred Physician services which are subject to the office visit Copayment.]
- [Outpatient Prescription Drugs.]
- charges in excess of the Allowable Charge.]]

[**FAMILY STOP-LOSS LIMIT**

- [**BluePreferred and BlueCard PPO Provider Services** — When you and your Dependents have Incurred [$[1,000–100,000]][the amount specified in the insert in the front of this Certificate](in excess of any [Copayment and/or] Deductible amounts) for Covered Services provided by BluePreferred and BlueCard PPO Providers during a Benefit Period, the amount of Allowable Charges covered by the Plan on behalf of all covered family members will increase to 100% during the remainder of the Benefit Period for Covered Services you receive from network Providers.]
- [**Out–of–Network Provider Services** — When you and your Dependents have Incurred [$[1,000–100,000]] [the amount specified in the insert in the front of this Certificate](in excess of any [Copayment and/or] Deductible amounts) for Covered Services provided by Out–of–Network Providers during a Benefit Period, the amount of Allowable Charges covered by the Plan on behalf of all covered family members will increase to 100% during the remainder of the Benefit Period for Out–of–Network Provider services.]

[When you and your Dependents have Incurred [$[1,000–100,000]] [the amount specified in the insert in the front of this Certificate](in excess of any [Copayment and/or] Deductible amounts) for Covered Services provided by BluePreferred or BlueCard PPO or Out–of–Network Providers during a Benefit Period, the amount of Allowable Charges covered by the Plan on behalf of all covered family members will increase to 100% during the remainder of the Benefit Period.]]

[**OUT-OF-POCKET LIMIT**

- [**BluePreferred and BlueCard PPO Provider Services** — When you have paid[$[1,000–100,000]] [the amount specified in the insert in the front of this Certificate](in excess of any [Copayment and/or] Deductible amounts) for Covered Services provided by BluePreferred and BlueCard PPO Providers during a Benefit Period, the amount of Allowable Charges covered by the Plan on your behalf will increase to 100% during the remainder of the Benefit Period for Covered Services you receive from network Providers.]

- [**Out–of–Network Provider Services** — When you have paid [$[1,000–100,000]] [the amount specified in the insert in the front of this Certificate](in excess of any [Copayment and/or] Deductible amounts) for Covered Services provided by Out–of–Network Providers during a Benefit Period, the amount of Allowable Charges covered by the Plan on your behalf will increase to 100% during the remainder of the Benefit Period for Out–of–Network Provider services.]

[When you have paid [$[1,000–100,000]] [the amount specified in the insert in the front of this Certificate](in excess of any [Copayment and/or] Deductible amounts) for Covered Services during a Benefit Period, the amount of Allowable Charges covered by the Plan on your behalf will increase to 100% during the remainder of the Benefit Period.]]

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

- [Psychiatric Care Services[(except for treatment of Severe Mental Illness)].]

- [BluePreferred Physician services which are subject to the office visit Copayment.]

- [Outpatient Prescription Drugs.]

- charges in excess of the Allowable Charge.]]

[**FAMILY OUT-OF-POCKET LIMIT**

- [**BluePreferred and BlueCard PPO Provider Services** – When you and your Dependents have paid [$[1,000–100,000]] [the amount specified in the insert in the front of this Certificate](in excess of any [Copayment and/or] Deductible amounts) for Covered Services provided by BluePreferred and BlueCard PPO Providers during a Benefit Period, the amount of Allowable Charges covered by the Plan on behalf of you and your Dependents will increase to 100% during the remainder of the Benefit Period for Covered Services received from network Providers.]

- [**Out–of–Network Provider Services** – When you and your Dependents have paid [$[1,000–100,000]] [the amount specified in the insert in the front of this Certificate](in excess of any [Copayment and/or] Deductible amounts) for Covered Services provided by Out–of–Network Providers during a Benefit Period, the amount of Allowable Charges covered by the Plan on behalf of you and your Dependents will increase to 100% during the remainder of the Benefit Period for Out–of–Network Provider services.]

[When you and your Dependents have paid [$[1,000–100,000]] [the amount specified in the insert in the front of this Certificate](in excess of any [Copayment and/or] Deductible amounts) for Covered Services provided by BluePreferred, BlueCard PPO or Out–of–Network Providers during a Benefit Period, the amount of Allowable Charges covered by the Plan on behalf of all covered family members will increase to 100% during the remainder of the Benefit Period.]

MAXIMUM

[$[250,000–10,000,000]]per lifetime per Subscriber, including any other limitations specifically stated in this Certificate.][Unlimited]

BENEFIT PERCENTAGE AMOUNT

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

COVERED SERVICES (Subject to the *Comprehensive Health Care Services* section which follows)	BENEFIT PERCENTAGE AMOUNT: BluePreferred & BlueCard PPO Provider Services	Out–of–Network Provider Services
[**ACCIDENTAL INJURY SERVICES** [(Limited to $[100–5,000] per Benefit Period)]	[50–100]%	[50–100]%]
HOSPITAL SERVICES	[50–100]%	[50–100]%
SURGICAL/MEDICAL SERVICES		
Physicians' Office Visits		
[Preventive Care Services [(Limited to $[100–5,000] per Benefit Period] [for Subscribers age [16–25] or older)]	[50–100]%	[50–100]%]
Annual Routine Gynecological/Obstetrical Examination and Pap Smear	[50–100]%	[50–100]%
Covered Childhood Immunizations [(Limited to Subscribers under age [19–25])]	[100]%	[100]%
Other Physicians' Office Visits	[50–100]%*	[50–100]%
All Other Covered Surgical/Medical Services	[50–100]%	[50–100]%
OUTPATIENT DIAGNOSTIC SERVICES		
Routine Low–Dose Mammography [(Limited to $[115–500] per screening)]	[100]%	[100]%
All Other Covered Diagnostic Services	[50–100]%	[50–100]%
OUTPATIENT THERAPY SERVICES	[50–100]%	[50–100]%
MATERNITY SERVICES	[50–100]%	[50–100]%
MASTECTOMY AND RECONSTRUCTIVE SURGICAL SERVICES	[50–100]%	[50–100]%
HUMAN ORGAN, TISSUE AND BONE MARROW TRANSPLANT SERVICES	[50–100]%	[50–100]%
AMBULATORY SURGICAL FACILITY SERVICES	[50–100]%	[50–100]%
[**PSYCHIATRIC CARE SERVICES**	[50–100]%	[50–100]%]

**Applicable only to Covered Services which are subject to the office visit Copayment. For services which are not subject to the office visit Copayment, this percentage amount is reduced to*[50–100]*% of Allowable Charges after satisfaction of the Deductible.*

COVERED SERVICES (Subject to the *Comprehensive Health Care Services* section which follows)	BENEFIT PERCENTAGE AMOUNT: BluePreferred & BlueCard PPO Provider Services	Out–of–Network Provider Services
[**PSYCHIATRIC CARE SERVICES**		
Covered Services for Treatment of Severe Mental Illness	[[50–100]%	[[50–100]%
All Other Covered Psychiatric Care Services	[50–100]%	[50–100]%]
AMBULANCE SERVICES	[50–100]%	[50–100]%
PRIVATE DUTY NURSING SERVICES	[50–100]%	[50–100]%
REHABILITATION CARE	[50–100]%	[50–100]%
SKILLED NURSING FACILITY SERVICES	[50–100]%	[50–100]%
HOME HEALTH CARE SERVICES	[50–100]%	[50–100]%
HOSPICE CARE SERVICES	[50–100]%	[50–100]%
[**OUTPATIENT PRESCRIPTION DRUGS AND RELATED SERVICES**	[50–100]%*	[50–100]%]
ALL OTHER COVERED SERVICES	[50–100]%	[50–100]%

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

Schedule of Benefits
Comprehensive Health Care Services

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

BENEFIT PERIOD

[Calendar Year][Contract Year]

[**OFFICE VISIT COPAYMENT**

[$[0–100] for each visit to the Physician's office.][The amount specified in the insert in the front of this Certificate.] The Copayment applies to charges which are billed as part of your Physician's office visit.

EXCEPTION: The office visit Copayment does not apply to the following services:

- [Surgical services.]
- [[Speech Therapy,]Physical Therapy and Occupational Therapy.]
- [Chemotherapy.]
- [Allergy testing and allergy injections.]
- Covered childhood immunizations[(for Subscribers under age [19–25]).
- [Psychiatric Care Services.]
- [Prescription Drugs.]
- [Durable Medical Equipment.]

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

DEDUCTIBLE

[Emergency Room Deductible

[$[50–1,000] per each visit to a Hospital emergency room.][The amount specified in the insert in the front of this Certificate.] [This Deductible is waived if you are admitted to the Hospital through the emergency room visit.]]

[Outpatient Surgery Deductible

[$[100–5,000] per each visit to an Outpatient facility for Surgery.][The amount specified in the insert in the front of this Certificate.] This Deductible applies to surgical procedures received in a Hospital Outpatient department or Ambulatory Surgical Facility.]

[Hospital Admission Deductible

[$[100–5,000] per each visit to an Outpatient facility for Surgery.][The amount specified in the insert in the front of this Certificate.] This Deductible applies to surgical procedures received in a Hospital Outpatient department or Ambulatory Surgical Facility.

[Benefit Period Deductible

[$[100–10,000] per Benefit Period per Subscriber.][The amount specified in the insert in the front of this Certificate.]

The Benefit Period Deductible is in addition to [the office visit Copayment and]any other Deductible described above.

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

- [Routine Nursery Care.]
- Annual prostate cancer screening [(limited to $[65–200] per screening)].
- Routine Low–Dose Mammography [(limited to $[115–500] per screening)].
- Physician office visits for Subscribers under age [19–25] (including covered childhood immunizations).
- [Physician office visits for Subscribers age [19–99] and over (limited to the first [one–10] visits per Benefit Period).]
- [Preventive Care Services [(limited to $[100–5,000] per Benefit Period for Subscribers age [16–25] and over)].]
- [Prescription Drugs.]
- [Ambulance Services.]]

[Deductible Carryover

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

[Deductible Credit

If your Group changed carriers during your benefit period, expenses you Incurred and which were applied toward your Deductible during the last partial benefit period for services covered by the prior carrier will be applied to the Deductible of your initial Benefit Period under this Certificate.]

[FAMILY DEDUCTIBLE

[If your coverage includes your Dependents, then:

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

[If your coverage includes your Dependents, then no more than [two–three] Subscribers covered under that membership must satisfy their Deductibles in one Benefit Period.]

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

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

[STOP-LOSS LIMIT

[When you have Incurred [$[1,000–100,000]][the amount specified in the insert in the front of this Certificate] (in excess of any [Copayment and/or]Deductible amounts) for Covered Services during a Benefit Period, the amount of Allowable Charges covered by the Plan on your behalf will increase to 100% during the remainder of the Benefit Period.]

[The Stop–Loss Limit and Benefit percentage amount specified above do not apply to expenses Incurred for[:]

- [Psychiatric Care Services][(except for treatment of Severe Mental Illness)].]
- [Physician services which are subject to the office visit Copayment.]
- [Outpatient Prescription Drugs.]
- charges in excess of the Allowable Charge.]]

[FAMILY STOP-LOSS LIMIT

When you and your Dependents have Incurred [$[1,000–100,000]][the amount specified in the insert in the front of this Certificate] (in excess of any [Copayment and/or]Deductible amounts) for Covered Services during a Benefit Period, the amount of Allowable Charges covered by the Plan on behalf of you and your family will increase to 100% during the remainder of the Benefit Period.

[OUT-OF-POCKET LIMIT

When you have paid [$[1,000–100,000]][the amount specified in the insert in the front of this Certificate](in excess of any [Copayment and/or]Deductible amounts) for Covered Services during a Benefit Period, the amount of Allowable Charges covered by the Plan on your behalf will increase to 100% during the remainder of the Benefit Period.

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

- [Psychiatric Care Services[(except for treatment of Severe Mental Illness)].]
- [Physician services which are subject to the office visit Copayment.]
- [Outpatient Prescription Drugs.]
- [charges in excess of the Allowable Charge.]]

[FAMILY OUT-OF-POCKET LIMIT

When you and your Dependents have paid [$[1,000–100,000]][the amount specified in the insert in the front of this Certificate] (in excess of any [Copayment and/or]Deductible amounts) for Covered Services during a Benefit Period, the amount of Allowable Charges covered by the Plan on behalf of you and your Dependents will increase to 100% during the remainder of the Benefit Period.]

MAXIMUM

[$[250,000–10,000,000] per lifetime per Subscriber, including any other limitations specifically stated in this Certificate.] [Unlimited]

BENEFIT PERCENTAGE AMOUNT

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

COVERED SERVICES (Subject to the *Comprehensive Health Care Services* section which follows)	BENEFIT PERCENTAGE AMOUNT:			
	BluePreferred or BlueCard PPO Provider Services	**BlueChoice Provider Services**	**BlueTraditional Provider Services**	**Out–of–Network Provider Services**
HOSPITAL SERVICES	[50–100]%	[50–100]%	[50–100]%	[50–100]%
SURGICAL/MEDICAL SERVICES				
Physicians' Office Visits				
Subscribers under age [19–25]	[50–100]%	[50–100]%	[50–100]%	[50–100]%
Subscribers age [19–99] and over [(limited to the first [one–10] visits per Benefit Period)]	[50–100]%	[50–100]%	[50–100]%	[50–100]%
[Subscribers age [19–99] and over (visits which exceed [one–10] per Benefit Period)]	[50–100]%	[50–100]%	[50–100]%	[50–100]%
Preventive Care Services [(Limited to $[100–5,000] per Benefit Period)[for Subscribers age [16–25] and over)]	[50–100]%	[50–100]%	[50–100]%	[50–100]%
All Other Covered Surgical/Medical Services	[50–100]%	[50–100]%	[50–100]%	[50–100]%
OUTPATIENT DIAGNOSTIC SERVICES				
Routine Low–Dose Mammography [(Limited to $[115–500] per screening)]	[100]%	[100]%	[100]%	[100]%
All Other Covered Diagnostic Services	[50–100]%	[50–100]%	[50–100]%	[50–100]%
OUTPATIENT THERAPY SERVICES	[50–100]%	[50–100]%	[50–100]%	[50–100]%
MATERNITY SERVICES	[50–100]%	[50–100]%	[50–100]%	[50–100]%
MASTECTOMY AND RECONSTRUCTIVE SURGICAL SERVICES	[50–100]%	[50–100]%	[50–100]%	[50–100]%
HUMAN ORGAN, TISSUE AND BONE MARROW TRANSPLANT SERVICES	[50–100]%	[50–100]%	[50–100]%	[50–100]%

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

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

Schedule of Benefits
Comprehensive Health Care Services

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

BENEFIT PERIOD

[Calendar Year][Contract Year]

[OFFICE VISIT COPAYMENT

[$[0–100] for each visit to the Physician's office.][The amount specified in the insert in the front of this Certificate.] The Copayment applies to charges which are billed as part of your Physician's office visit.

EXCEPTION: The office visit Copayment does not apply to the following services:

- [Surgical services.]
- [Radiology, ultrasound and nuclear medicine.]
- [ECG, EEG, and other Electronic Diagnostic Medical Procedures and Physiological Medical Testing.]
- [Laboratory and pathology.]
- [[Speech Therapy,]Physical Therapy and Occupational Therapy.]
- [Chemotherapy.]
- [Allergy testing and allergy injections.]
- Covered childhood immunizations[(for Subscribers under age [19–25]).
- [Psychiatric Care Services.]
- [Prescription Drugs.]
- [Durable Medical Equipment.]

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

DEDUCTIBLE

[Emergency Room Deductible

[$[50–1,000] per each visit to a Hospital emergency room.][The amount specified in the insert in the front of this Certificate.] [This Deductible is waived if you are admitted to the Hospital through the emergency room visit.]]

[Outpatient Surgery Deductible

[$[100–5,000] per each visit to an Outpatient facility for Surgery.][The amount specified in the insert in the front of this Certificate.] This Deductible applies to surgical procedures received in a Hospital Outpatient department or Ambulatory Surgical Facility.]

[Hospital Admission Deductible

[$[100–5,000] per each visit to an Outpatient facility for Surgery.][The amount specified in the insert in the front of this Certificate.] This Deductible applies to surgical procedures received in a Hospital Outpatient department or Ambulatory Surgical Facility.

[Benefit Period Deductible

[$[100–10,000] per Benefit Period per Subscriber.][The amount specified in the insert in the front of this Certificate.]

The Benefit Period Deductible is in addition to [the office visit Copayment and]any other Deductible described above.

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

- [Routine Nursery Care.]
- Annual prostate cancer screening [(limited to $[65–200] per screening)].
- Routine Low–Dose Mammography [(limited to $[115–500] per screening)].
- Physician office visits, including [associated [laboratory][and] [x–ray] services][*],] [and]covered childhood immunizations for Subscribers under age [19–25].
- [Physician office visits [, including associated [laboratory][and] [x–ray] services,][*] for Subscribers age [19–99] and over (limited to the first [one–10] visits per Benefit Period).]
- [Preventive Care Services [(limited to $[100–5,000] per Benefit Period for Subscribers age [16–25] and over)].]
- [Prescription Drugs.]
- [Ambulance Services.]]

[Deductible Carryover

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

[*Includes [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), electroencephalogram (EEG), echocardiogram, myocardial perfusion studies (MPS), and other similar imaging tests][;] [and] [pathology and laboratory procedures under the CPT code classifications of Cytogenetic Studies, Surgical Pathology, or Transcutaneous Procedures].]

[Deductible Credit

If your Group changed carriers during your benefit period, expenses you Incurred and which were applied toward your Deductible during the last partial benefit period for services covered by the prior carrier will be applied to the Deductible of your initial Benefit Period under this Certificate.]

[**FAMILY DEDUCTIBLE**

[If your coverage includes your Dependents, then:

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

[If your coverage includes your Dependents, then no more than [two–three] Subscribers covered under that membership must satisfy their Deductibles in one Benefit Period.]

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

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

[**STOP-LOSS LIMIT**

[When you have Incurred [$[1,000–100,000]][the amount specified in the insert in the front of this Certificate] (in excess of any [Copayment and/or]Deductible amounts) for Covered Services during a Benefit Period, the amount of Allowable Charges covered by the Plan on your behalf will increase to 100% during the remainder of the Benefit Period.]

[The Stop–Loss Limit and Benefit percentage amount specified above do not apply to expenses Incurred for[:]

- [Psychiatric Care Services][(except for treatment of Severe Mental Illness)].]
- [Physician services which are subject to the office visit Copayment.]
- [Outpatient Prescription Drugs.]
- charges in excess of the Allowable Charge.]]

[**FAMILY STOP-LOSS LIMIT**

When you and your Dependents have Incurred [$[1,000–100,000]][the amount specified in the insert in the front of this Certificate] (in excess of any [Copayment and/or]Deductible amounts) for Covered Services during a Benefit Period, the amount of Allowable Charges covered by the Plan on behalf of you and your family will increase to 100% during the remainder of the Benefit Period.

[OUT-OF-POCKET LIMIT

When you have paid [$[1,000–100,000]][the amount specified in the insert in the front of this Certificate](in excess of any [Copayment and/or]Deductible amounts) for Covered Services during a Benefit Period, the amount of Allowable Charges covered by the Plan on your behalf will increase to 100% during the remainder of the Benefit Period.

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

- [Psychiatric Care Services[(except for treatment of Severe Mental Illness)].]
- [Physician services which are subject to the office visit Copayment.]
- [Outpatient Prescription Drugs.]
- [charges in excess of the Allowable Charge.]]

[FAMILY OUT-OF-POCKET LIMIT

When you and your Dependents have paid [$[1,000–100,000]][the amount specified in the insert in the front of this Certificate] (in excess of any [Copayment and/or]Deductible amounts) for Covered Services during a Benefit Period, the amount of Allowable Charges covered by the Plan on behalf of you and your Dependents will increase to 100% during the remainder of the Benefit Period.]

MAXIMUM

[$[250,000–10,000,000] per lifetime per Subscriber, including any other limitations specifically stated in this Certificate.] [Unlimited]

BENEFIT PERCENTAGE AMOUNT

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

COVERED SERVICES (Subject to the *Comprehensive Health Care Services* section which follows)	BENEFIT PERCENTAGE AMOUNT:			
	BluePreferred or BlueCard PPO Provider Services	**BlueChoice Provider Services**	**BlueTraditional Provider Services**	**Out–of–Network Provider Services**
HOSPITAL SERVICES	[50–100]%	[50–100]%	[50–100]%	[50–100]%
SURGICAL/MEDICAL SERVICES				
Physicians' Office Visits				
Subscribers under age [19–25]	[50–100]%[*]	[50–100]%[*]	[50–100]%[*]	[50–100]%[*]
Subscribers age [19–99] and over [(limited to the first [one–10] visits per Benefit Period)]	[50–100]%[*]	[50–100]%[*]	[50–100]%[*]	[50–100]%[*]
[Subscribers age [19–99] and over (visits which exceed [one–10] per Benefit Period)]	[50–100]%[*]	[50–100]%[*]	[50–100]%[*]	[50–100]%[*]
Preventive Care Services [(Limited to $[100–5,000] per Benefit Period][for Subscribers age [16–25] and over)]	[50–100]%	[50–100]%	[50–100]%	[50–100]%
All Other Covered Surgical/Medical Services	[50–100]%	[50–100]%	[50–100]%	[50–100]%
OUTPATIENT DIAGNOSTIC SERVICES				
Routine Low–Dose Mammography [(Limited to $[115–500] per screening)]	[100]%	[100]%	[100]%	[100]%
All Other Covered Diagnostic Services[*][**]	[50–100]%	[50–100]%	[50–100]%	[50–100]%

[**Includes*[*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), electroencephalogram (EEG), echocardiogram, myocardial perfusion studies (MPS), and other similar imaging tests*][*;*] [*and*] [*pathology and laboratory procedures under the CPT code classifications of Cytogenetic Studies, Surgical Pathology, or Transcutaneous Procedures*].]

[*][**][*Certain diagnostic laboratory* [*and x–ray*] *services may be covered under "Physician's Office Visits" as set forth under Surgical/Medical Services.*]

COVERED SERVICES (Subject to the *Comprehensive Health Care Services* section which follows)	BENEFIT PERCENTAGE AMOUNT:			
	BluePreferred or BlueCard PPO Provider Services	BlueChoice Provider Services	BlueTraditional Provider Services	Out–of–Network Provider Services
OUTPATIENT THERAPY SERVICES	[50–100]%	[50–100]%	[50–100]%	[50–100]%
MATERNITY SERVICES	[50–100]%	[50–100]%	[50–100]%	[50–100]%
MASTECTOMY AND RECONSTRUCTIVE SURGICAL SERVICES	[50–100]%	[50–100]%	[50–100]%	[50–100]%
HUMAN ORGAN, TISSUE AND BONE MARROW TRANSPLANT SERVICES	[50–100]%	[50–100]%	[50–100]%	[50–100]%
AMBULATORY SURGICAL FACILITY SERVICES	[50–100]%	[50–100]%	[50–100]%	[50–100]%
[PSYCHIATRIC CARE SERVICES	[50–100]%	[50–100]%	[50–100]%	[50–100]%]
AMBULANCE SERVICES	[50–100]%	[50–100]%	[50–100]%	[50–100]%
PRIVATE DUTY NURSING SERVICES	[50–100]%	[50–100]%	[50–100]%	[50–100]%
REHABILITATION CARE	[50–100]%	[50–100]%	[50–100]%	[50–100]%
SKILLED NURSING FACILITY SERVICES	[50–100]%	[50–100]%	[50–100]%	[50–100]%
HOME HEALTH CARE SERVICES	[50–100]%	[50–100]%	[50–100]%	[50–100]%
HOSPICE CARE SERVICES	[50–100]%	[50–100]%	[50–100]%	[50–100]%

COVERED SERVICES (Subject to the *Comprehensive Health Care Services* section which follows)	BENEFIT PERCENTAGE AMOUNT:			
	BluePreferred or BlueCard PPO Provider Services	BlueChoice Provider Services	BlueTraditional Provider Services	Out–of–Network Provider Services
[OUTPATIENT PRESCRIPTION DRUGS AND RELATED SERVICE	[50–100]%*	[50–100]%*	[50–100]%*	[50–100]%*]
ALL OTHER COVERED SERVICES	[50–100]%	[50–100]%	[50–100]%	[50–100]%

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

Schedule of Benefits
Comprehensive Health Care Services

This section shows how much we pay for Covered Services described in the ***Comprehensive Health Care Services*** section that follows. It also outlines the Deductible and other shared payment provisions that apply to your coverage. **Please note that services must be Medically Necessary in order to be covered under this program.**

BENEFIT PERIOD	[Calendar Year][Contract Year]
DEDUCTIBLE	
[Out–of–Network Hospital Deductible	[$[100–5,000]per Inpatient Hospital Admission.] [The amount specified in the insert in the front of this Certificate.] This Deductible applies to all Covered Services Incurred during the Subscriber's admission to a Hospital.]
[Hospital Admission Deductible	[$[100–5,000] for each visit to a Hospital.] [The amount specified in the insert in the front of this Certificate.] This Deductible applies to all Covered Services Incurred during the Subscriber's admission to a Hospital[, except Routine Nursery Care.]
[Emergency Room Deductible	[$[50–1,000] for each visit to a Hospital emergency room.][The amount specified in the insert in the front of this Certificate.] [This Deductible is waived if the Subscriber is admitted to the Hospital through the emergency room visit.]]
[Outpatient Surgery Deductible	[$[100–5,000] for each visit to an Outpatient facility for Surgery.] [The amount specified in the insert in the front of this Certificate.]This Deductible applies to surgical procedures received in a Hospital Outpatient department or Ambulatory Surgical Facility.]
[Benefit Period Deductible	[$[100–10,000] per Benefit Period per Subscriber.] [The amount specified in the insert in the front of this Certificate.] The Deductible applies to all Covered Services, except: • [Accidental Injury Services (Deductible will apply after eligible charges exceed $[100–5,000] for all Accidental Injury Service during the Benefit Period).] • [Routine Nursery Care.] • [Preventive Care Services [for Subscribers age [16–25] or older] [(limited to $[100–5,000] per Benefit Period).]] • [Annual routine gynecological/obstetrical examination and Pap smear.]

- Annual prostate cancer screening [(limited to $[65–200] per screening)].
- Covered childhood immunizations [(for Subscribers under age [19–25])].
- Routine Low–Dose Mammography [(limited to $[115–500] per screening).]
- [Ambulance Services.]]

[Deductible Carryover

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

[Deductible Credit

If your Group changed carriers during your benefit period, expenses you Incurred and which were applied toward your Deductible during the last partial benefit period for services covered by the prior carrier will be applied to the Deductible of your initial Benefit Period under this Certificate.]

[**FAMILY DEDUCTIBLE**

[If your coverage includes your Dependents, then:

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

[If your coverage includes your Dependents, then no more than [two–three] Subscribers covered under that membership must satisfy their Deductibles in one Benefit Period.]

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

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

[STOP-LOSS LIMIT

When you have Incurred [$[1,000–100,000]][the amount specified in the insert in the front of this Certificate] in excess of any Deductible amount for Covered Services during a Benefit Period, the amount of Allowable Charges covered by the Plan on your behalf will increase to 100% during the remainder of the Benefit Period.]

[The Stop–Loss Limit and Benefit percentage amount specified above do not apply to expenses Incurred for[:]

- [Psychiatric Care Services [(except for treatment of Severe Mental Illness)].]
- [Outpatient Prescription Drugs.]
- charges in excess of the Allowable Charge.]]

[FAMILY STOP-LOSS LIMIT

When you and your Dependents have Incurred [$[1,000–100,000]][the amount specified in the insert in the front of this Certificate]in excess of anyDeductible amount for Covered Services during a Benefit Period, the amount of Allowable Charges covered by the Plan on behalf of all covered family members will increase to 100% during the remainder of the Benefit Period.]

[OUT-OF-POCKET LIMIT

When you have paid [$[1,000–100,000]][the amount specified in the insert in the front of this Certificate] in excess of anyDeductible amount for Covered Services during a Benefit Period, the amount of Allowable Charges covered by the Plan on your behalf will increase to 100% during the remainder of the Benefit Period.]

[The Stop–Loss Limit and Benefit percentage amount specified above do not apply to expenses Incurred for[:]

- [Psychiatric Care Services [(except for treatment of Severe Mental Illness)];]
- [Outpatient Prescription Drugs.]
- charges in excess of the Allowable Charge.]]

[FAMILY OUT-OF-POCKET LIMIT

When you and your Dependents have paid [$[1,000–100,000]][the amount specified in the insert in the front of this Certificate] in excess of anyDeductible amount for Covered Services during a Benefit Period, the amount of Allowable Charges covered by the Plan on behalf of all covered family members will increase to 100% during the remainder of the Benefit Period.]

MAXIMUM	[$[250,000–10,000,000] per lifetime per Subscriber, including any other limitations specifically stated in this Certificate.][Unlimited]
BENEFIT PERCENTAGE AMOUNT	The following chart shows the percentage of Allowable Charges covered by your BlueTraditional program through payments and/or contractual arrangements with Providers. These percentages apply only after your Deductible, and/or Coinsurance has been satisfied. The percentage shown is applicable to Covered Services received from a BlueTraditional or BlueCard Provider. The allowance for Covered Services rendered by an Out–of–Network Provider is specified in the ***General Provisions*** section.

COVERED SERVICES (Subject to the *Comprehensive Health Care Services* section which follows)	BENEFIT PERCENTAGE AMOUNT:
[ACCIDENTAL INJURY SERVICES [(Limited to $[100–5,000] per Benefit Period)]	[50–100]%]
HOSPITAL SERVICES	[50–100]%
SURGICAL/MEDICAL SERVICES	
[Preventive Care Services [(Limited to $[100–5,000] per Benefit Period] [for Subscribers age [16–25] or older)]	[50–100]%]
[Annual Routine Gynecological/Obstetrical Examination and Pap Smear	[50–100]%]
Covered Childhood Immunizations [(Limited to Subscribers under age[19–25])]	[100]%
All Other Covered Surgical/Medical Services	[50–100]%
OUTPATIENT DIAGNOSTIC SERVICES	
Routine Low–Dose Mammography [(Limited to $[115–500] per screening)]	[100]%
All Other Covered Diagnostic Services	[50–100]%
OUTPATIENT THERAPY SERVICES	[50–100]%
MATERNITY SERVICES	[50–100]%
MASTECTOMY AND RECONSTRUCTIVE SURGICAL SERVICES	[50–100]%
HUMAN ORGAN, TISSUE AND BONE MARROW TRANSPLANT SERVICES	[50–100]%
AMBULATORY SURGICAL FACILITY SERVICES	[50–100]%
[PSYCHIATRIC CARE SERVICES	[50–100]%]
[PSYCHIATRIC CARE SERVICES	
Covered Services for Treatment of Severe Mental Illness	[50–100]%
All Other Covered Psychiatric Care Services	[50–100]%]
AMBULANCE SERVICES	[50–100]%
PRIVATE DUTY NURSING SERVICES	[50–100]%
REHABILITATION CARE	[50–100]%
SKILLED NURSING FACILITY SERVICES	[50–100]%

COVERED SERVICES (Subject to the *Comprehensive Health Care Services* section which follows)	BENEFIT PERCENTAGE AMOUNT:
HOME HEALTH CARE SERVICES	[50–100]%
HOSPICE CARE SERVICES	[50–100]%
[OUTPATIENT PRESCRIPTION DRUGS AND RELATED SERVICES	[50–100]%*]
ALL OTHER COVERED SERVICES	[50–100]%

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

Comprehensive Health Care Services

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

[Accidental Injury Services

We pay the scheduled Benefits for Covered Services you receive from a Hospital, Physician, or other Provider to treat accidental injury.

Covered Services also include the services of an RN, LPN, or LVN who is not a member of your immediate family and does not usually live with you.

For purposes of this section, an accidental injury includes all related symptoms and recurrent conditions resulting from that accident.

The following are not covered under this section:

- Ptomaine poisoning, disease or infection (except pyogenic infection occurring through an accidental cut or wound);
- Dentistry of any kind;
- Purchase of medicines for use outside a Hospital;
- Poison ivy, oak or sumac; sunburn; frostbite; adverse reactions to medicines; blisters; insect bites; and the like;
- Ambulance Services.

After we have paid the maximum Benefits for these Accidental Injury Services, expenses you incur to treat accidental injury will be subject to the scheduled Deductible and percentage amount of the Allowable Charge for Covered Services.]

Hospital Services

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

- **Bed and Board**

  Bed, board and general nursing service in:

  — A room with two or more beds;

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

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

  Inpatient services are subject to the Precertification guidelines of this Certificate (see *"Important Information"*). If you fail to comply with these guidelines, Benefits for Covered Services rendered during

your Inpatient confinement will be reduced by $[0–1,000], provided the Plan determines that Benefits are payable upon receipt of a claim.

- **Ancillary Services**

  — Operating, delivery and treatment rooms;

  — Prescribed drugs;

  — Whole blood, blood processing and administration;

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

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

  — Oxygen;

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

  — Diagnostic Services;

  — Therapy Services.

  [**Benefits for Speech Therapy are limited to Inpatient services only.**]

- **Emergency Accident Care**

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

- **Emergency Medical Care**

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

- **Surgery**

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

- **Routine Nursery Care**

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

  — Routine Nursery Care does not include treatment or evaluation for medical or surgical reasons during or after the mother's maternity confinement. In the event the newborn requires such treatment or evaluation while covered under this Certificate:

    ○ the infant will be considered as a Subscriber in its own right and will be entitled to the same Benefits as any other Subscriber under this Certificate; and

    ○ a separate Deductible will apply to the newborn's Hospital confinement.

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

SURGICAL/MEDICAL SERVICES

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

- **Surgery**

  Payment includes visits before and after Surgery.

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

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

    ○ the primary procedure; plus

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

  — Sterilization, regardless of Medical Necessity.

- **Assistant Surgeon**

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

- **Anesthesia**

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

- **Inpatient Medical Services**

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

  — Inpatient Medical Care Visits

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

  — Intensive Medical Care

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

  — Concurrent Care

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

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

  — Consultation

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

  — Newborn Well Baby Care

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

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

- **Outpatient Medical Services**

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

  — Emergency Accident Care

  Treatment of accidental bodily injuries.

  — Emergency Medical Care

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

  — Home, Office, and Other Outpatient Visits

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

  — [Preventive Care Services

  Services performed by a Provider as "routine" or "screening" services[, **limited to $**[100–5,000] **per Benefit Period**] [**for Subscribers age** [16–25] **or older**.] Routine or screening examinations which meet the guidelines for mandated Benefits, established by Oklahoma state law, shall not be included as Preventive Care Services, but shall be subject to the limitations specified elsewhere in this Certificate.

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

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

  — Routine Gynecological/Obstetrical Examination and Pap Smear

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

  — Contraceptive Devices

  Contraceptive devices which are:

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

  — Prostate Cancer Screening

  Annual screening for the early detection of prostate cancer in male Subscribers, including a prostate–specific antigen blood test and a digital rectal examination. [**Benefits are limited to one screening exam per Benefit Period and shall not exceed $**[65–200] **per screening.**]

  — Colorectal Cancer Screening

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

  — Immunizations, limited to:

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

- Tetanus vaccine;
- Poliomyelitis vaccine;
- Measles virus vaccine;
- Mumps virus vaccine;
- German measles (rubella) vaccine;
- Measles, mumps, and rubella vaccine (MMR);
- Varicella (chicken pox) vaccine;
- Pneumonia vaccine;
- Pneumococcal vaccine;
- Haemophilus influenzae type b (Hib);
- Rotavirus vaccine[, **limited to Subscribers under age** [19–25]];
- Human papillovirus vaccine (HPV)[, **limited to Subscribers under age** [19–25]];
- Hepatitis A and hepatitis B vaccine[, **limited to Subscribers under age** [19–25]];
- Meningococcal vaccine[, **limited to Subscribers under age** [19–25]];
- Any other immunization required for children by the Oklahoma State Board of Health.

— Child Health Supervision Services

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

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

Child Health Supervision Services are limited to Subscribers under age [19–25]**.**

— Audiological Services

Audiological services and hearing aids, limited to:

- One hearing aid per ear every 48 months[for Subscribers up to age [18–25]]; and
- Up to four additional ear molds per Benefit Period for Subscribers up to two years of age.

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

— Bone Density Testing

Bone density testing when ordered or performed by a Physician or other Provider. [**Benefits are limited to $**[150–500] **for each bone density test**.]

Outpatient Diagnostic Services

- Radiology, Ultrasound and Nuclear Medicine

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

— [one screening examination every five years for female Subscribers age 35 through 39; and]

— one *annual* screening examination for female Subscribers age [19–40] or older.

Benefits for *routine* Low–Dose Mammography shall be limited to $[115–500] per screening.

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

Outpatient Therapy Services

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

  [**Benefits for Outpatient Physical Therapy and Outpatient Occupational Therapy are limited to a combined maximum of [5–365] visits per Benefit Period per Subscriber.**]

- [Speech Therapy]

  [**Benefits for Outpatient Speech Therapy is limited to a maximum of [5–365] visits per Benefit Period per Subscriber.**]

- [Physical Therapy, Occupational Therapy and Speech Therapy]

  [**Benefits for Outpatient Physical Therapy, Outpatient Occupational Therapy and Outpatient Speech Therapy are limited to a combined maximum of [5–365] visits per Benefit Period per Subscriber.**]

Maternity Services

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

  — Normal Pregnancy

  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

- Covered Maternity Services include the following:

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

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

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

- training or assistance with breast or bottle feeding; and
- performance of any Medically Necessary and appropriate clinical tests.

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

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

Mastectomy and Reconstructive Surgical Services

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

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

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

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

- **DEFINITIONS**

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

  - **Bone Marrow Transplant**

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

    - the harvest of stem cells or progenitor cells, whether from the bone marrow or from the blood, from a third–party donor (allogeneic transplant) or from the patient (autologous transplant);

- processing and/or storage of the stem cells or progenitor cells after harvesting;
- the administration of High−Dose Chemotherapy and/or High−Dose Radiation Therapy, when this step is prescribed by the treating Physician;
- the infusion of the harvested stem cells or progenitor cells; and
- hospitalization, observation and management of reasonably anticipated complications such as graft versus host disease, infections, bleeding, organ or system toxicities and low blood counts.

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

— **Experimental/Investigational**

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

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

— **High−Dose Chemotherapy**

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

— **High−Dose Radiation Therapy**

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

— **Precertification**

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

— **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 Certificate, 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 Plan for assessing and performing organ or tissue transplants, or Bone Marrow Transplant procedures, as set forth in the Plan's written medical policies.

  — In addition to the Exclusions set forth elsewhere in this Certificate, no Benefits will be provided for the following organ or tissue transplants or Bone Marrow Transplants or related services:

    ○ Adrenal to brain transplants.

    ○ Allogeneic islet cell transplants.

    ○ High−Dose Chemotherapy or High−Dose Radiation Therapy if the associated autologous or allogeneic Bone Marrow Transplant, stem cell or progenitor cell treatment or rescue is not a Covered Service.

    ○ Small bowel transplants using a living donor.

    ○ Any organ or tissue transplant or Bone Marrow Transplant from a non−human donor or for the use of non−human organs for extracorporeal support and/or maintenance.

    ○ Any artificial device for transplantation/implantation, except in limited instances as reflected in the Plan's written medical policies.

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

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

- **DONOR BENEFITS**

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

— When both the recipient and the living donor are Subscribers, each is entitled to the Benefits of this Certificate.

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

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

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

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

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

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

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

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

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

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

Ambulatory Surgical Facility Services

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

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

Psychiatric Care Services

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

- Inpatient Facility Services

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

- Inpatient Medical Services

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

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

  — Individual Psychotherapy;

  — Group Psychotherapy;

  — Psychological Testing; and

  — Convulsive Therapy Treatment.

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

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

- Outpatient Psychiatric Care Services

  — Facility and Medical Services

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

  — Day/Night Psychiatric Care Services

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

- [Drug Abuse and Alcoholism

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

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

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

[**Your Benefits for Psychiatric Care Services will not exceed:**]

- [30–365] **days' Inpatient Psychiatric Care Services per Benefit Period per Subscriber.**
- [5–365] **visits per Benefit Period per Subscriber for Outpatient Psychiatric Care Services.**

Ambulance Services

- Medically Necessary transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured:
  - — From your home to a Hospital;
  - — From the scene of an accident or medical emergency to a Hospital;
  - — Between Hospitals;
  - — Between a Hospital and a Skilled Nursing Facility; 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 $**[100–20,000] **per Benefit Period per Subscriber.**]

Rehabilitation Care

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

[**Rehabilitation Care is limited to** [30–365] **days of Inpatient care per Benefit Period per Subscriber.**]

Rehabilitation Care is subject to the Precertification guidelines of this Certificate (see "*Important Information*"). Failure to comply with these guidelines will result in a $[0–1,000] **reduction in Benefits for Rehabilitation Care if, upon receipt of a claim, Benefits are payable under this Certificate.**

Skilled Nursing Facility Services

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

[**Skilled Nursing Facility Services are limited to** [30–365] **days of Inpatient care per Benefit Period per Subscriber.**]

Skilled Nursing Facility Services are subject to the Precertification guidelines of this Certificate (see "*Important Information*"). Failure to comply with these guidelines will result in a $[0–1,000]** **reduction in Benefits for Skilled Nursing Facility Services if, upon receipt of a claim, Benefits are payable under this Certificate.**

No Benefits are payable:

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

Home Health Care Services

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

- Medical and surgical supplies;
- Prescribed drugs;
- Oxygen and its administration;
- **Up to** [30–365] **visits per Benefit Period per Subscriber, limited to the following:**
  - Professional services of an RN, LPN, or LVN;
  - Medical social service consultations;
  - Health aide services while you are receiving covered nursing or Therapy Services;
  - Services of a licensed registered dietician or licensed certified nutritionist, when authorized by the patient's supervising Physician and when Medically Necessary as part of diabetes self–management training.

Home Health Care is subject to the Precertification guidelines of this Certificate (see "*Important Information*"). Failure to comply with these guidelines will result in a $[0–1,000]** **reduction in Benefits for Home Health Care if, upon receipt of a claim, Benefits are payable under this Certificate.**

We do not pay Home Health Care Benefits for:

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

Hospice Services

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

[**Benefits for Hospice Services are limited to $**[1,000–30,000] **per Benefit Period per Subscriber.**]

Hospice Services are subject to the Precertification guidelines of this Certificate (see "*Important Information*"). Failure to comply with these guidelines will result in a $[0–1,000] **reduction in Benefits for Hospice Services, if, upon receipt of a claim, Benefits are payable under this Certificate.**

Dental Services for Accidental Injury

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

[Outpatient Prescription Drugs and Related Services

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

- Prescription Drugs dispensed for a Subscriber's Outpatient use, when recommended by and while under the care of a Physician or other Provider;
- Injectable insulin and insulin products, but only when dispensed in accordance with a written prescription by a licensed Physician;
- Oral contraceptives, when prescribed by a licensed Physician;
- Prescription Drugs prescribed for treatment of attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD) [for Subscribers age [19–25]and under,] subject to the Plan's guidelines for Precertification; and
- Self–injectable Prescription Drugs, when dispensed by a Pharmacy. Self–injectable drugs purchased from a Physician and administered in his/her office are not covered.

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

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

- **Up to a** [30–60]**–day supply for "non–maintenance" drugs; or**
- **Up to a** [90–270]**–day supply for nitroglycerin, natural thyroid products, and other drugs designated by the Plan as "maintenance" legend Prescription Drugs.**]

Diabetes Equipment, Supplies and Self–Management Services

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

— Visual reading and urine testing strips;

— Insulin;

— Injection aids;

— Cartridges for the legally blind;

— Syringes;

— Insulin pumps and appurtenances thereto;

— Insulin infusion devices;

— Oral agents for controlling blood sugar;

— Podiatric appliances for prevention of complications associated with diabetes; and

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

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

  — Visits Medically Necessary upon the diagnosis of diabetes;

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

  — Visits when reeducation or refresher training is Medically Necessary.

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

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

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

Durable Medical Equipment

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

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

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

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

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

[**Benefits for Durable Medical Equipment will not exceed $**[500–60,000] **per Benefit Period per Subscriber.**]

Prosthetic Appliances

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

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

[**Benefits for prosthetic appliances will not exceed $**[500–60,000] **per Benefit Period per Subscriber.**]

Orthotic Devices

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

Benefits will be provided for the following orthotic devices:

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

Not covered are:

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

[**Benefits for orthotic devices will not exceed $**[500–60,000] **per Benefit Period per Subscriber.**]

Wigs or Other Scalp Prostheses

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

[**Benefits are limited to $**[150–500] **per Benefit Period per Subscriber.**]

[*Schedule of Benefits*
Outpatient Prescription Drugs

This section shows the Copayment/Coinsurance amounts that apply to the Covered Services described in the ***Outpatient Prescription Drug Benefits*** section that follows**. Please note that services must be Medically Necessary in order to be covered under this program.**

BENEFIT PERIOD	[Calendar Year][Contract Year]
[**DEDUCTIBLE**	$[1–1,000] per Benefit Period per Subscriber.]
[**COPAYMENT/COINSURANCE**	The Copayment or Coinsurance applicable to each Prescription Order is set forth below:]
[**COINSURANCE**	The Copayment or Coinsurance applicable to each Prescription Order is [25–100]%]
[**COPAYMENT**	The Copayment applicable to each Prescription Order is set forth below:]
[**Generic Drugs**	[25–100]% Coinsurance with a $[10–100] minimum Copayment, to be applied as follows:

Quantity Dispensed	**Copayment/Coinsurance**
1 to 30 days	[25–100]% of Allowable Charges with a $[10–100] minimum
31 to 60 days*	[25–100]% of Allowable Charges with a $[10–100]minimum
61 to 90 days*	[25–100]% of Allowable Charges with a $[10–100]minimum]

* Maintenance drugs only.

[**Generic Drugs** $[10–100] Copayment to be applied as follows:

Quantity Dispensed	Number of Copayments
1 to 30 days	1 Copayment
31 to 60 days*	2 Copayments
61 to 90 days*	3 Copayments]

[**Preferred Drugs** $[10–100] Copayment to be applied as follows:

Quantity Dispensed	Number of Copayments
1 to 30 days	1 Copayment
31 to 60 days*	2 Copayments
61 to 60 days*	3 Copayments]

[**Non–Preferred Brand Drugs** [25–100]% Coinsurance with a $[10–100] minimum Copayment, to be applied as follows:

Quantity Dispensed	Copayment/Coinsurance
1 to 30 days	[25–100] %of Allowable Charges with a $[10–100] minimum
31 to 60 days*	[25–100]%of Allowable Charges with a $[10–100] minimum
61 to 90 days*	[25–100]% of Allowable Charges with a $[10–100] minimum]

[**Non–Preferred Brand Drugs** $[10–100] Copayment, to be applied as follows:

Quantity Dispensed	Number of Copayments
1 to 30 days	1 Copayment
31 to 60 days*	2 Copayments
61 to 90 days*	3 Copayments]

[**Retail Pharmacy Program**

The Copayment applicable to each Prescription Order dispensed by a Participating Retail Pharmacy is set forth below:]

[**Generic Drugs**

$[0–100] **Copayment**

The Copayment will be applied as follows:

Quantity Dispensed	**Number of Copayments**
1 to 30 days	1 Copayment
31 to 60 days*	2 Copayments
61 to 90 days*	3 Copayments]

[**Preferred Drugs**

$[1–500] **Copayment**

The Copayment will be applied as follows:

Quantity Dispensed	**Number of Copayments**
1 to 30 days	1 Copayment
31 to 60 days*	2 Copayments
61 to 90 days*	3 Copayments]

[**Non–Preferred Brand Drugs**

$[1–500] **Copayment**

The Copayment will be applied as follows:

Quantity Dispensed	**Copayment/Coinsurance**
1 to 30 days	1 Copayment
31 to 60 days*	2 Copayments
61 to 90 days*	3 Copayments]

[**Specialty Pharmacy Drugs**

$[1–1,000] **Copayment, limited to a** [30–60]**–day supply or** [50–500] **dose units, whichever is less**]

* Maintenance drugs only.

[**Mail–Order Pharmacy Program***]	The Copayment applicable to each Prescription Order dispensed through the Plan's Mail Order Service is set forth below:]
[**Generic Drugs**	**$**[1–500] **Copayment for a** [90–270]**–day supply**]
[**Preferred Drugs**	**$**[1–500] **Copayment for a** [90–270]**–day supply**]
[**Non–Preferred Brand Drugs**	**$**[1–500] **Copayment for a** [90–270]**–day supply**]
[**Specialty Pharmacy Drugs**	**Not available through the Mail Order Service**]
[**STOP-LOSS LIMIT**] [**OUT-OF-POCKET LIMIT**]	[When a Subscriber has [Incurred] [paid]$[100–10,000] during a Benefit Period for Covered Outpatient Prescription Drugs and related services, the amount of Allowable Charges covered by the Plan on behalf of such Subscriber will increase to 100% during the remainder of the Benefit Period for Outpatient Prescription Drugs and related services.]]

[*Outpatient Prescription Drug Benefits*

Subject to the Exclusions, conditions, and limitations of this Certificate, a Subscriber is entitled to the Benefits of this section for covered Outpatient Prescription Drugs and related services, subject to the [[Deductible,] Copayment or Coinsurance] [[Deductible or]Coinsurance] [[Deductible or]Copayment]amounts specified in the ***Schedule of Benefits for Outpatient Prescription Drugs.***

Covered Services

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

- Prescription Drugs dispensed for a Subscriber's Outpatient use, when recommended by and while under the care of a Physician or other Provider;
- Injectable insulin and insulin products, but only when dispensed in accordance with a written prescription by a licensed Physician;
- Oral contraceptives, when prescribed by a licensed Physician;
- Prescription Drugs prescribed for treatment of attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD) [for Subscribers age [19–25] and under,] subject to the Plan's guidelines for Precertification; and
- Self–injectable Prescription Drugs, when dispensed by a Pharmacy. Self–injectable drugs purchased from a Physician and administered in his/her office are not covered. [**NOTE:** Many self–injectable drugs are classified as "Specialty Pharmacy Drugs" and must be purchased from a Participating Specialty Pharmacy in order for you to receive the maximum Benefits under this program.]

Benefits will not be provided for Prescription Drugs prescribed and used for cosmetic purposes or for compounded medications. For purposes of this exclusion, "compounded medications" are substances made by mixing, reconstituting or other such acts, not in accordance with directions contained in Food and Drug Administration (FDA) approved labeling provided by the product's manufacturer and other FDA–approved manufacturer directions consistent with that labeling.

[Mail-Order Pharmacy Program

All items that are covered under the Mail Order Service are the same items that are covered under the Retail Pharmacy Program and are subject to the same limitations and exclusions. **Items covered through a Specialty Pharmacy may not be covered through the Mail Order Service.** NOTE: Prescription Drugs and other items may not be mailed outside the United States. Extended supplies or vacation overrides required when you are outside the United States may be approved through the Retail Pharmacy Program only.

[Only maintenance drugs are available through the Plan's Mail Order Service.]]

Payment of Benefits

- Benefits are provided for Prescription Drugs dispensed for a Subscriber's Outpatient use when recommended by and while under the care of a Physician or other Provider, provided such care and treatment is Medically Necessary.

- When Prescription Drugs are dispensed by a Participating Pharmacy, [and after the Subscriber has satisfied the Deductible,] the Plan will pay directly to the Pharmacy the Allowable Charge for the drugs, less the applicable [Copayment] [Coinsurance] [Copayment or Coinsurance] specified in the ***Schedule of Benefits for Outpatient Prescription Drugs***]

- When Prescription Drugs are dispensed by a Pharmacy which is not a Participating Pharmacy, [and after the Subscriber has satisfied the Deductible,] Benefits are reduced to [50–100]% of the Allowable Charge for the drugs, less the applicable [Copayment][Coinsurance][Copayment or Coinsurance].

- Benefits for Prescription Drugs are available to the Subscriber only:

  — in accordance with a Prescription Order; and

  — [after the Subscriber has met the Deductible for that Benefit Period; and]

  — after the Subscriber has incurred charges equal to the [Copayment][Coinsurance] [Copayment or Coinsurance] applicable to each Prescription Order. **If the charge for your prescription is *less* than your [Copayment][Coinsurance] [Copayment or Coinsurance], you will pay the lesser amount.**

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

  — Up to a [30–60]–day supply or [50–500]unit doses (whichever is [less] [more]) for "non–maintenance" drugs; or

  — Up to a [90–270]–day supply or[50–1,000] unit doses (whichever is [less] [more]) for nitroglycerin, natural thyroid products, and other drugs designated by the Plan as "maintenance" legend Prescription Drugs.

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

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

- Charges Incurred for Prescription Drugs do not count toward satisfaction of the Deductible or [Stop–Loss] [Out–of–Pocket] Limit which apply to Comprehensive Health Care Services (set forth in the ***Schedule of Benefits for Comprehensive Health Care Services***).

Prescription Drug Precertification Process

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

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

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

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

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

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

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

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

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

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

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

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

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

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

— If Precertification is approved for the drug, you may return to the Pharmacy to obtain the full Prescription Order, subject to any [[Deductible,] Copayment or Coinsurance] [[Deductible or]Coinsurance] [[Deductible or]Copayment] amount applicable to the balance of the drug quantity dispensed.

— If the Precertification is denied, you may obtain your Prescription Order by paying the full cost for the drugs.

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

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

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

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

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

[*Schedule of Benefits*
Covered Dental Services

This section shows how much the Plan pays for Covered Services described in the ***Covered Dental Services*** section that follows.

[**BENEFIT PERIOD**	[Calendar Year][Contract Year]]
[**DEDUCTIBLE**	[None–$1,000]]
[**MAXIMUM**	[None–$5,000]per Benefit Period per Subscriber.]
COVERED SERVICES	**BENEFIT PERCENTAGE AMOUNT*:**
Basic Dental Services	[50–100]% of the Allowable Charge for Covered Services.]

**Percentage of Allowable Charges covered by the Plan through payments and/or contractual arrangements with Dentists, after the Subscriber's shared payment amount has been satisfied.*

[*Covered Dental Services*

Subject to the Exclusions, conditions, and limitations of this Certificate, a Subscriber is entitled to the Benefits of this section for Covered Services rendered by a Dentist in the amounts specified in the ***Schedule of Benefits***.

Covered Services

Basic Dental Services consisting of the following:

- The initial oral examination and periodic oral examinations, limited to [one–five] examinations per Benefit Period.
- Dental x–rays.
  - — One full–mouth or panoramic x–ray every [12–60] months.
  - — Bitewing x–rays as required.
- Prophylaxis (cleaning, scaling, and polishing of teeth), limited to [one–five] times per Benefit Period.
- Topical fluoride application for Subscribers under age [one–19], limited to [one–five] times per Benefit Period.
- Repair of full or partial removable dentures.
- Palliative emergency treatment and emergency oral examinations. Palliative treatment consists of minor procedures, not including permanent restorations or services. Palliative treatment and definitive treatment cannot be performed on the same tooth on the same date of service.
- Space maintainers when used to maintain space due to prematurely lost teeth, limited to Subscribers under age [12–25].
- Sealants for permanent first and second molars free from caries and restorations on the occlusal surfaces for Subscribers under age [12–25], limited to one application per tooth every [12–60]months.
- Amalgam and composite fillings.
- Simple extractions, not including extractions of impacted teeth.
- Endodontics, including pulpotomy, direct pulp capping and root canal treatment. Surgical procedures performed in connection with root canal treatment are not covered.
- Stainless steel crowns for primary teeth only.

Special Exclusions and Limitations

- Care Rendered By More Than One Dentist

  In the event a Subscriber transfers from the care of one Dentist to another Dentist during a course of treatment, or if more than one Dentist renders services for one dental procedure, the Plan will be liable for not more than the amount for which it would have been liable had but one Dentist rendered the services.

- Alternate Course of Treatment

  In all cases involving services in which the Dentist or the Subscriber selects a course of treatment, Benefits will be based on the procedure that is consistent with sound professional standards of dental practice for the dental condition concerned and which carries the lesser fee.

- Non–Compliance with Prescribed Care

  Any additional treatment and resulting liability which is caused by the lack of a Subscriber's cooperation with the Dentist or from non–compliance with prescribed dental care will be the responsibility of the Subscriber.

- Exclusions

  In addition to the exclusions and limitations specified in the ***Exclusions*** section of this Certificate, no Benefits will be provided under this ***Covered Dental Services*** section for:

  — Veneers or similar properties of crowns and pontics placed on or replacing teeth.

  — Prosthetic devices (including bridges and crowns) and the fitting thereof.

  — Replacement of bridges, dentures or other prosthetic devices or appliances.

  — Replacement or repair of an orthodontic appliance.

  — Any duplicate prosthetic device or any other duplicate appliance.

  — Oral hygiene and dietary instruction.

  — Plaque control programs.

  — Dental implants.

  — Procedures, appliances or restorations necessary to increase vertical dimensions and/or restore or maintain functional or centric occlusion.

  — Local anesthesia, or analgesia, when billed for separately.

  — IV sedation or general anesthesia.

  — Case presentations or detailed and extensive treatment planning when billed for separately.

  — Periodontics or oral surgical procedures, unless specifically provided.

  — Any service not specifically listed as a Covered Service in this ***Covered Dental Services*** section.]

[*Schedule of Benefits*
Covered Vision Services

This section shows *how much* and *how often* the Plan pays for Covered Services described in the ***Covered Vision Services*** section that follows.

COVERED SERVICES	THE PLAN PAYS:
Vision Testing Examination	$[30–100]
Frames	$[30–100]
Conventional Lenses (per pair)	
Single vision lenses	$[30–100]
Bifocal vision lenses	$[30–100]
Trifocal vision lenses	$[30–100]
Aphakic–aspheric or lenticular	$[25–500]
Contact Lenses (per pair)	
When Medically Necessary*	$[155–500]
Regardless of Medical Necessity	
Single vision lenses	$[60–250]
Bifocal vision lenses	$[75–250]

The Plan pays the above amounts for Vision Testing Examinations, Lenses (per pair), and Frames (if Conventional Lenses) once every [12–24] months for Subscribers under age [19–25], and once every [24–48] months for all other Subscribers.]

* *"Medically Necessary" means contact lenses prescribed when visual acuity cannot otherwise be corrected to at least 20/70 in the better eye or when prescribed for aphakic conditions either congenital or from Surgery.*

[*Covered Vision Services*

The Plan provides Benefits for the following Covered Services when rendered by a Physician, optometrist or optician:

Covered Services

- **Vision Testing Examination**

  A vision testing examination consisting of, but not limited to, these component services:

  — a case history;

  — external examination of the eye and adnexa;

  — ophthalmoscopic examination;

  — determination of refractive status;

  — binocular balance testing;

  — tonometry test for glaucoma;

  — gross visual fields;

  — color vision testing;

  — summary findings; and

  — recommendations, including prescribing of corrective lenses.

- **Prescribed Lenses and Frames**

  Prescribed lenses and frames, including the following directly related Provider services:

  — facial measurements and determination of interpupillary distance;

  — assistance in selection of frames;

  — procurement of lenses and frames;

  — verification of lenses as prescribed; and

  — after–care for a period of six months for fitting and adjustment and maintenance of comfort and efficiency.

- **Prescribed Contact Lenses**

Exclusions

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

- Special Exclusions and Limitations
  - Benefits for prescription sunglasses or lenses made from lens blanks more than 65 millimeters in diameter or blended/progressive power (multifocal) lenses, photosensitive lenses or anti–reflective lenses or other nonstandard lenses will be limited to the amount payable for the corresponding single vision, bifocal vision, trifocal vision or aphakic, clear lenses as specified in the ***Schedule of Benefits***. **Lenses with a tint darker than Rose Tint #2 are considered to be sunglasses.**
  - Benefits for contact lenses which are not Medically Necessary will be equal to but not more than the amount payable for single vision or bifocal vision clear conventional lenses and one frame.
  - Separate Benefits will not be provided for a contact lenses suitability examination performed at the same time as a vision testing examination. If received at a time different from that of a vision testing examination, the contact lenses suitability examination will be considered a vision testing examination, subject to the limitations on frequency described in the ***Schedule of Benefits***.
- Except as specifically provided, no Benefits are provided for:
  - Vision testing examinations, lenses or frames:
    - Which are not prescribed by or performed by or upon the direction of a Physician, optometrist, or optician;
    - Which are Experimental/Investigational in nature;
    - Which are necessitated by your employment or furnished as a condition of employment;
    - Received as a result of eye disease, defect or injury suffered after the Subscriber's Effective Date as a result of war or act of war declared or undeclared, when serving in the military or any auxiliary unit thereto;
    - For industrial safety glasses or goggles whether or not a prescription is required;
    - Which do not meet accepted standards of ophthalmological practice.
  - Any vision care and services, supplies, or charges:
    - For any illness or injury occurring in the course of employment if whole or partial compensation or benefits are or might have been available under the laws of any governmental unit; any policy of workers' compensation insurance; or according to any recognized legal remedy arising from an employer–employee relationship. This applies whether or not you claim the benefits or compensation or recover the losses from a third party;
    - 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 which Benefits are provided under any other contract underwritten by the Plan, or any other Blue Cross or Blue Shield Plan;
    - For which the Provider customarily makes no direct charge to a Subscriber;
    - For replacement of lost, broken, stolen or damaged lenses, contact lenses, or frames unless at the time of replacement you are eligible under the frequency provisions of this Certificate;
    - For which a Subscriber would have no legal obligation to pay in the absence of this or any similar coverage;

- For drugs or medication not administered for the purpose of vision testing examination;
- For medical or surgical treatment;
- For specialized or unusual procedures (as the Plan determines), including, but not limited to: orthoptics, vision training or tonography;
- Received before your Effective Date;
- Received after your coverage terminates;
- For the completion of any claim forms;
- For lenses which do not require a prescription;
- For a vision testing examination made within 90 days following cataract surgery when rendered by the Physician who performed the cataract surgery;
- Other than those specifically listed under this Certificate.

Subscriber/Provider Relationship

This vision care program offers Subscribers a free choice of Physicians, optometrists, and opticians. We do not furnish Covered Services but only pay for Covered Services you receive from Providers. We are not liable for any act or omission of any Provider. We have no responsibility for a Provider's failure or refusal to give Covered Services to you.

If you use the services of any member of the healing arts who is licensed by any state of the United States or its territories to perform services within the scope of his/her license which, if performed by a Physician, optometrist, or optician, would be considered eligible for Benefits under this Certificate, then Benefits will be provided regardless of which healing art performs the service.]

Exclusions

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

WHAT IS NOT COVERED

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

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

- For cosmetic Surgery or complications resulting therefrom, including Surgery to improve or restore your appearance, unless:

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

  — for the improvement of the physiological functioning of a malformed body member, except for services related to Orthognathic Surgery, osteotomy, or any other form of oral Surgery, dentistry, or dental processes to the teeth and surrounding tissue.

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

- Received from a member of your immediate family.

- Received before your Effective Date.

- For any Inpatient care and services, including rehabilitation care and services, unless documentation can be provided that, due to the nature of the services rendered or your condition, you cannot receive safe or adequate care as an Outpatient.

- Received after your coverage stops.

- For personal hygiene and convenience items regardless of whether or not recommended by a Physician or other Provider. Examples include: computers; air conditioners, air purifiers or filters; humidifiers; physical fitness equipment, including exercise bicycles or treadmills; or modifications to your home or vehicle.

- For telephone consultations, email or other electronic consultations, missed appointments, or completion of a claim form.

- For Custodial Care such as sitters' or homemakers' services, care in a place that serves you primarily as a residence when you do not require skilled nursing, or for rest cures.

- For foot care only to improve comfort or appearance such as care for flat feet, subluxation, corns, bunions (except capsular and bone Surgery), calluses, toenails, and the like.

- For routine, screening or periodic physical examinations, except as specified in the ***Comprehensive Health Care Services*** section.

- For reverse sterilization.

- For contraceptive medications or devices which are sold without a Physician's prescription (including condoms; contraceptive foam, sponges, or cream; or other spermicides).

- For Orthognathic Surgery, osteotomy, or any other form of oral Surgery, dentistry, or dental processes to the teeth and surrounding tissue (including complications resulting therefrom), except for:

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

  — for the improvement of the physiological functioning of a malformed body member.

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

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

— severely disabled; or

— eight years of age or under;

and who has a medical or emotional condition which requires hospitalization or general anesthesia for dental care.

- [For ***Comprehensive Health Care Services*** related to eyeglasses, contact lenses or examinations for prescribing or fitting them, except for aphakic patients (including lenses required after cataract Surgery) and soft lenses or sclera shells to treat disease or injury. Vision examinations not related to the prescription or fitting of lenses will be a Covered Service only when performed in connection with the diagnosis or treatment of disease or injury, or as specifically provided under the ***Vision Care Services*** section of this Certificate.]

- [For eyeglasses, contact lenses or examinations for prescribing or fitting them, except for aphakic patients (including lenses required after cataract Surgery) and soft lenses or sclera shells to treat disease or injury. Vision examinations not related to the prescription or fitting of lenses will be a Covered Service only when performed in connection with the diagnosis or treatment of disease or injury. Eye refractions are not covered in any event.]

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

- For hearing aids, tinnitus maskers, or examinations for prescribing or fitting them, except as specified for Subscribers under age [18–25]. Hearing examinations not related to the prescription or fitting of hearing aids will be a Covered Service only when performed in connection with the diagnosis or treatment of disease or injury.

- [For Speech Therapy and any related diagnostic testing, except as provided by a Hospital or rehabilitation facility as part of a covered Inpatient stay.]

- For transsexual Surgery or any treatment leading to or in connection with transsexual Surgery.

- [For diagnosis, treatment or medications for infertility and fertilization procedures. Examples include any form of: artificial insemination; ovulation induction procedures; in vitro fertilization; embryo transfer; or any other procedures, supplies or medications which in any way are intended to augment or enhance your reproductive ability.]

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

- [For treatment of obesity, including morbid obesity, regardless of the patient's history or diagnosis, including but not limited to the following: weight reduction or dietary control programs; surgical procedures; prescription or nonprescription drugs or medications such as vitamins (whether to be taken orally or by injection), minerals, appetite suppressants, or nutritional supplements; and any complications resulting from weight loss treatments or procedures.]

- [For compounded medications. For purposes of this exclusion, "compounded medications" are substances made by mixing, reconstituting or other such acts, not in accordance with directions contained in Food and Drug Administration (FDA) approved labeling provided by the product's manufacturer and other FDA–approved manufacturer directions consistent with that labeling.]

- [For Prescription Drugs prescribed and used for cosmetic purposes.]

- [For drugs and medicines purchased by a Subscriber on an Outpatient basis, with or without a Physician's prescription, including drugs and medicines dispensed in the Physician's office, in the Outpatient department of a Hospital, or other Outpatient setting.]

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

- [For conditions related to [autistic disease of childhood,] [hyperkinetic syndromes,] learning disabilities, behavioral problems, [mental retardation,] or for Inpatient confinement for environmental change. This exclusion ***shall not*** apply to the following Medically Necessary services:

  — Physicians' services [(except for neuropsychological testing)] related to the diagnosis and treatment of attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD)[for Subscribers age [19–25] and under][; or

  — Prescription Drug therapy [(provided this Certificate includes Benefits for Outpatient Prescription Drugs)] for treatment of ADD/ADHD in Subscribers age [19–25] and under].]

- [For family or marital counseling.]

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

- For which the Provider of service customarily makes no direct charge to a Subscriber.

- Received from a Skilled Nursing Facility, Home Health Care Agency, Hospice, or rehabilitation facility which is not a Plan–approved Provider.

- For treatment of temporomandibular joint dysfunction, including but not limited to diagnostic procedures, splints, orthodontic/orthopedic appliances, restorations necessary to increase vertical dimension or to restore or maintain functional or centric occlusion, alteration of teeth or jaws, Physical Therapy, and medication and behavioral modification related to conditions of temporomandibular joint syndrome or any other conditions involving the jaw joint, adjacent muscles or nerves, regardless of cause or diagnosis.

- For or related to transplantation of donor organs, tissues or bone marrow, except as specified under "***Human Organ, Tissue and Bone Marrow Transplant Services***".

- For Physician standby services.

- For Continuous Passive Motion (CPM) devices used in treatment of the shoulder or other joints, except for up to 21 days postoperatively for the following surgical procedures: total knee arthroplasty, anterior cruciate ligament reconstruction, or open reduction and internal fixation of tibial plateau for distal femur fractures involving the knee joint.

- For ductal lavage of the mammary ducts.

- For extracorporeal shock wave treatment, also known as orthotripsy, using either a high– or low–dose protocol, for treatment of plantar fasciitis and all other musculoskeletal conditions.

- For orthoptic training.

- For thermal capsulorraphy as a treatment of joint instability, including but not limited to instability of shoulders, knees and elbows.

- For transcutaneous electrical nerve stimulator (TENS).

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

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

- [For services rendered by midwives.]

- Which are not specifically named as Covered Services subject to any other specific Exclusions and limitations in this Certificate.

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

Preexisting Condition Exclusion

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

- [Three–Six]**–month Look–back Rule**

  — The Preexisting Condition Exclusion must relate to a condition (whether physical or mental, and regardless of the cause of the condition) for which medical advice, diagnosis, care, or treatment was recommended or received within the [three–six]–month period ending on the Subscriber's Enrollment Date.

  — In order to be taken into account, the medical advice, diagnosis, care, or treatment must have been recommended or received from an individual licensed or similarly authorized to provide such services under state law and operating within the scope of practice authorized by state law.

  — The [three–six]–month look–back period is based on the [three–six]–month "anniversary date" of the Enrollment Date.

- **Length of Preexisting Condition Exclusion Period**

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

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

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

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

- **Elimination of Preexisting Condition Exclusion for Pregnancy and for Certain Children**

  A Preexisting Condition Exclusion cannot apply to pregnancy. In addition, a Preexisting Condition Exclusion period will not be applied to a newborn, an adopted child under age 18, or a child Placed for Adoption under age 18, if the child becomes covered within [31–90] days of birth, adoption, or Placement for Adoption.

- **Notice to Subscribers**

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

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

The Plan may, without waiving the above provisions, elect to provide Benefits for care and services while awaiting the decision of whether or not the care and services fall within the above Preexisting Condition limitations. If it is later determined that the care and services are excluded from the Subscriber's coverage, the Plan will be entitled to recover the amount it has allowed for Benefits under this Certificate. The Subscriber must provide the Plan with all documents it needs to enforce its 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;
- Your relationship with us;
- Coordination of Benefits when you have other coverage.

Benefits to Which You Are Entitled

We provide only the Benefits specified in this Certificate.

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

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

Prior Approval

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

Notice and Properly Filed Claim

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

[Your Properly Filed Claim must be furnished to the Plan within [[30–365] days][[one–12]months] after the end of the Benefit Period for which the claim is made.] [Your Properly Filed Claim must be furnished to the Plan within [[30–365] days][[one–12]months] following the date of service for which the claim is made.] [Your Properly Filed Claim must be furnished to the Plan no later than [January–December] [1st–31st] of the Calendar Year following the year in which the Covered Services are Incurred.]

Failure to provide a Properly Filed Claim to the Plan 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 [two–five]years after expiration of the time within which a Properly Filed Claim is required by this Certificate.

Payment of Benefits

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

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

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

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

[In some cases, Covered Services may be rendered by a Provider who has a Participating Provider Agreement (*other than a* [BluePreferred][BlueChoice PPO] *Provider Agreement*) with the Plan. These Providers (called BlueTraditional Providers) have agreed to charge Plan Subscribers no more than a "Maximum Reimbursement Allowance" for Covered Services. Subscribers 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 Blue Cross and Blue Shield Subscribers who receive Covered Services outside the state of Oklahoma.

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

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

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

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

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

Determination of Benefits and Utilization Review

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

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

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

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

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

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

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

Subscriber/Provider Relationship

The choice of a Provider is solely yours.

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

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

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

Agency Relationships

The Group is your agent, not our agent.

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

Coordination of Benefits

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

- **Definitions**

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

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

— Group, blanket or franchise insurance coverage;

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

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

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

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

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

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

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

- **Effect On Benefits**

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

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

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

- **Order Of Benefit Determination**

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

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

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

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

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

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

- **Facility Of Payment**

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

- **Right Of Recovery**

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

[Pharmacy Benefit Administration

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

Plan's Right of Recoupment

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

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

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

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

Limitations on Plan's Right of Recoupment/Recovery

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

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

[Out–of–Network Provider Reimbursement

The Benefit amounts specified in the ***Schedule of Benefits*** apply to Covered Services rendered by a BlueTraditional Provider which are regularly included in the charges billed by and payable to such Provider.

The Benefits for Covered Services rendered by an Out–of–Network Provider, which are regularly included in the charges billed by and payable to such Provider, are as follows:

- For Covered Services rendered by an Out–of–Network Hospital or an Out–of–Network Ambulatory Surgical Facility in the State of Oklahoma, *a Subscriber shall be entitled to 80% of the percentage amount of the Allowable Charge that would be payable if such services were received under the same conditions in a BlueTraditional Hospital or BlueTraditional Ambulatory Surgical Facility.* **However, this reduction in Benefits will not apply in the case of Covered Services Incurred for Emergency Care rendered by an Out–of–Network Hospital in the State of Oklahoma. These Covered Services will be payable at the same percentage amount of the Allowable Charge that would be payable if the services were rendered by a BlueTraditional Hospital.**
- Subscribers receiving Covered Services in Hospitals or Ambulatory Surgical Facilities in any state other than Oklahoma or any territory of the United States shall be entitled to the same percentage amount of the Allowable Charge that would be payable if such services were received in BlueTraditional Hospitals or BlueTraditional Ambulatory Surgical Facilities.

- For Covered Services rendered by any Provider other than an Out–of–Network Hospital or Out–of–Network Ambulatory Surgical Facility, the Subscriber shall be entitled to the same percentage amount of the Allowable Charge that would be payable if such services were rendered by a BlueTraditional Provider.]

PLAN/ASSOCIATION RELATIONSHIP

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

Subscriber Rights

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

You have the right to:

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

Claims Filing Procedures

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

Participating Provider Networks

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

REMEMBER . . .

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

[Prescription Drug Claims

To be eligible for discounts on Prescription Drugs and automatic claims filing, always use Participating Pharmacies. Keep in mind that you receive the highest Benefits under this program whenever your prescriptions are filled by a Participating Pharmacy.

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

Hospital Claims

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

Ambulatory Surgical Facility Claims

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

Physician and Other Provider Claims

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

[Dental Claims

A Participating Dentist will file your claim for you. If you receive services from an Out–of–Network Dentist, you should arrange to pay the Dentist yourself and then file a claim. You will be paid directly for Covered Services after we subtract your shared payment.

Mail the completed claim form to:

[Blue Cross and Blue Shield of Oklahoma
c/o Dental Network of America, Inc.
P.O. Box 23100
Belleville, IL 62223–0100]]

Member-Filed Claims

When you must file a claim yourself, you may obtain claim forms by contacting the nearest Plan office.

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

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

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

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

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

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

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

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

[**Remember, we must receive your claims for Covered Services within** [[30–365] **days**][[one–12]**months**] **after the end of the Benefit Period for which the claim is made.**] [**Remember, we must receive your claims for Covered Services within** [[30–365] **days**][[one–12]**months**] **following the date of service for which the claim is made.**] [**Remember, we must receive your claims for Covered Services no later than [January–December]** [1st–31st] **of the Calendar Year following the year in which the Covered Services are Incurred.**]

Benefit Determinations for Properly Filed Claims

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

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

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

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

Direct Claims Line

We have a direct line for claims and membership inquiries. You may call [1–800–94 BLUES (1–800–942–5837)] between [[6:00–9:00] a.m. and [4:00–9:00]p.m.,] Monday through Friday, whenever you have a question concerning a claim or your membership.

[For questions regarding your dental coverage, you may call a Customer Service Reprsentative at [1–888–381–9727] between [[6:00–9:00] a.m. and [4:00–9:00]p.m.,] , Monday through Friday.]

Complaint/Appeal Procedure

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

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

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

APPEAL PROCESS (LEVEL I)

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

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

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

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

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

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

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

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

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

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

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

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

VOLUNTARY RE-REVIEW PROCESS (LEVEL II)

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

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

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

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

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

EXTERNAL REVIEW (LEVEL III)

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

You are not obligated by the Group Health Plan to pursue the Plan's voluntary re–review process or an external review in any specific order. You are not required to exhaust the voluntary re–review process before bringing a civil action. If the review process does not provide a satisfactory resolution to the claim for Benefits, legal remedies are available, including pursuing the claim in court.

[*Your ERISA Rights*

As a participant in this Group Health Plan, you may be entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). Check with your Group Administrator to see if your Group Health Plan is governed by ERISA.

ERISA Rights

If your claim for Benefits is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator (your Employer) to provide the materials and pay you up to $[110–500] a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.]

Definitions

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

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

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

[***For Outpatient Prescription Drug Benefits***, the Allowable Charge is determined as follows:

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

[***For Covered Dental Services***, the Allowable Charge is determined as follows:

- **Participating Dentists** — the amount the Dentist has agreed to accept as full payment for Covered Services.
- **Out–of–Network Dentists** — the Dentist's usual charge, up to the amount that the Plan would reimburse a Participating Dentist for Covered Services in the same geographic area.]

NOTE: For covered health care services received outside the state of Oklahoma, if the claim for those services is filed with the Blue Cross and Blue Shield Plan (Host Plan) servicing the area, the "Allowable Charge" will

be determined by the on–site Blue Cross and Blue Shield Plan. Payment will be based upon the Provider payment arrangements in effect between the Provider and the on–site Plan. In instances where the claim is not filed with the Host Plan, the Allowable Charge for your out–of–network claims will be based upon the amount the Plan would have reimbursed a [BluePreferred][BlueChoice PPO][BlueTraditional] Provider for the same service.

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.

[Annual Transfer Period

A period of [30–60] days immediately before the Contract Date Anniversary in which an Eligible Person who has coverage through the Employer's alternate Plan Group Contract [or BlueLincs HMO (if applicable)] can apply to transfer coverage to this Certificate.]

Benefit Period

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

Benefits

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

BlueCard [PPO] Provider

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

[BlueChoice PPO Provider

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

[BluePreferred Provider

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

[BlueTraditional Provider

A Provider who has entered into a BlueTraditional Provider Agreement with the Plan.]

[Calendar Year

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

Certificate of Coverage

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

COBRA Continuation Coverage

Coverage under the Group Contract 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 Contract to Subscribers to whom a Qualifying Event has not occurred.

Coinsurance

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

Community Home Health Care Agency

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

Contract

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

Contract Date

The date when coverage for your Group starts.

Contract Date Anniversary

The date the Group Contract will renew and each 12–consecutive–month renewal date thereafter.

[Contract Year

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

[Copayment

A fixed dollar amount required to be paid by or on behalf of a Subscriber in connection with the delivery of Covered Services in a [BluePreferred][BlueChoice PPO] Physician's office. [For Outpatient Prescription Drugs, the Copayment is the dollar amount required to be paid by or on behalf of a Subscriber for each Prescription Order.]]

[Copayment

The dollar amount required to be paid by or on behalf of a Subscriber for each Prescription Order.]

Covered Service

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

Creditable Coverage

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

Custodial Care

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

Deductible

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

[Dentist

A professional practitioner who holds a lawful license issued by any state of the United States, or its territories, authorizing the person to practice dentistry and dental Surgery in such state or territory, including, but not limited to, a Doctor of Dental Surgery (DDS) or a Doctor of Medical Dentistry (DMD).]

Dependent

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

Diagnostic Service

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

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

[Domestic Partner

An individual with whom the Member has entered into a domestic partnership, and who is determined to be an eligible Dependent under this Certificate.]

Durable Medical Equipment

Equipment which meets the following criteria:

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

Effective Date

The date when your coverage begins.

Eligible Person

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

Emergency Care

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

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

Employee

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

Employer

A Group, as defined, in which there exists an employment relationship between a Member and the Group.

Enroll

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

Enrollment Date

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

Experimental/Investigational

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

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

[Family Coverage

Coverage under this Certificate for the Member and one or more of the Member's Dependents.]

[Full-Time Student

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

- An undergraduate student enrolled in [six–15]or more semester hours, or the academic equivalent; or
- A graduate student enrolled in [three–nine]or more semester hours, or the academic equivalent; or
- A graduate assistant student enrolled in [three–nine] or more semester hours, or the academic equivalent.]

[Generic Drug

Pharmaceutically equivalent drug products substituted for the originator/trademarked (brand) drug products.]

Group

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

[Health Maintenance Organization (HMO)

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

Hospice

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

Hospital

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

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

Hospital Admission

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

Identification Card

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

Incurred

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

Individual Conversion

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

Initial Enrollment Period

The [31–90]–day period immediately following the date an Employee or Dependent first becomes eligible to Enroll for coverage under the Contract.

Inpatient

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

Late Enrollee

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

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

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

- the individual transfers from the Employer's alternate Plan Group Contract or BlueLincs HMO (if applicable) during the Annual Transfer Period; or
- a court has ordered coverage be provided for a spouse or minor or Dependent child under the Eligible Person's coverage and the request for enrollment is made within 31 days after issuance of the court order.

Licensed Practical or Vocational Nurse (LPN or LVN)

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

Low-Dose Mammography

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

Maternity Services

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

Medical Care

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

Medically Necessary (or Medical Necessity)

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

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

Medicare

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

Member

An Eligible Person who has enrolled for coverage.

[**Member and Children Coverage**

Coverage under this Certificate for the Member and his or her Dependent child(ren).]

[**Member Only Coverage** [(or Single Coverage)]

Coverage under this Certificate for the Member only.]

[**Member, Spouse and Children Coverage** [(or Family Coverage)]

Coverage under this Certificate for the Member, his or her spouse and Dependent child(ren).]

[**Member and Spouse Only Coverage**

Coverage under this Certificate for the Member and his or her spouse only.]

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.

[Non-Preferred Brand Drug

A name–brand Prescription Drug which has not been designated by the Plan as a Preferred Drug.]

Open Enrollment Period

A period of [30–60]days immediately before the Group's Contract Date Anniversary (renewal date) during which an individual who previously declined coverage may Enroll for coverage under the Contract 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 Dentist

A Dentist who has not entered into an agreement to be a part of the Plan's Participating Dentist network.]

[Out-of-Network Pharmacy

A Pharmacy that has not entered into a Participating Pharmacy Agreement with the Plan.]

Out-of-Network Provider

A Provider that has not entered into an agreement with the Plan to be a part of its [BluePreferred or BlueCard PPO][BlueChoice PPO or BlueCard PPO][BluePreferred, BlueChoice, BlueTraditional or BlueCard PPO][BlueTraditional or BlueCard]Provider networks.

[Out-of-Pocket Limit

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

- **Member–Only (Single) Coverage** — When you have satisfied the Out–of–Pocket Limit specified in the Schedule of Benefits, no additional Deductible or Coinsurance will be required for Covered Services you incur during the remainder of the Benefit Period.
- **Family Coverage** — When any *one or more* covered family members have paid the Out–of–Pocket Limit specified in the Schedule of Benefits, no additional Deductible or Coinsurance will be required for Covered Services Incurred by any Subscribers under that same Family Coverage 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 this Certificate.]

Outpatient

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

[Participating Dentist

A Dentist who has entered into an agreement with the Plan to bill the Plan directly for Covered Services, and to accept the Plan's allowance as payment for such Covered Services. Participating Dentists include the following:

- A Dentist who has entered into a Participating Provider Agreement with Blue Cross and Blue Shield of Oklahoma;
- A Dentist who has contracted directly with any division or subsidiary of Health Care Service Corporation (HCSC);

- A Dentist who is a member of any other network with which Health Care Service Corporation or any of its subsidiaries has contracted.]

[**Participating Pharmacy**

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

[**Pharmacy**

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

Physician

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

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

Blue Cross and Blue Shield of Oklahoma.

Precertification

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

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

Preexisting Condition

A condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the [three–six]–month period ending on the Enrollment Date. In order to be taken into account, the medical advice, diagnosis, care, or treatment must have been recommended by or received from an individual licensed or similarly authorized to provide such services under state law and operating within the scope of practice authorized by the state law. A Preexisting Condition does not include pregnancy, nor will it be applied to a newborn or adopted child under age 18, as long as the child became covered under the Certificate within [31–90] days of birth or adoption.

Preexisting Condition Exclusion

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

[**Preferred Drug**

A Prescription Drug which has been designated by the Plan to be a part of its Preferred Prescription Drug Program.]

[**Prescription Drug**

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

[**Prescription Order**

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

Properly Filed Claim

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

Provider

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

Qualifying Event

Any one of the following events which, but for the COBRA Continuation Coverage provisions of this Certificate, would result in the loss of a Subscriber'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 Contract.

[Referral Care

Care and services provided by an Out–of–Network Provider which are Medically Necessary and could not have been provided by a BlueChoice PPO Provider in a manner consistent with your needs.]

Registered Nurse (RN)

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

Routine Nursery Care

Ordinary Hospital nursery care of the newborn Subscriber.

[Severe Mental Illness

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

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

Significant Break In Coverage

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

[Single Coverage

Coverage under this Certificate for the Member only.]

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 Contract without having to wait until the Group's next regular Open Enrollment Period.

[Specialty Pharmacy Drugs

Prescription Drugs that meet at least two of the following criteria:

- they are high cost;
- they are for use in limited patient populations or indications;
- they are typically self–injected;
- they have limited availability, require special dispensing, or delivery and/or patient support is required and, therefore, they are difficult to obtain via traditional Pharmacy channels;
- complex reimbursement procedures are required; and/or
- a considerable portion of the use costs are frequently generated through office–based medical claims.]

[Stop-Loss Limit

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

Subscriber

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

Surgery

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

Therapy Service

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

- **Radiation Therapy** — the treatment of disease by x–ray, radium, or radioactive isotopes.
- **Chemotherapy** — the treatment of malignant disease by chemical or biological antineoplastic agents, but not including High–Dose Chemotherapy. High–Dose Chemotherapy is specifically addressed in certain sections under ***"Human Organ, Tissue and Bone Marrow Transplant Services."***
- **Respiratory Therapy** — introduction of dry or moist gases into the lungs for treatment purposes.

- **Dialysis Treatment** — the treatment of an acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body to include hemodialysis or peritoneal dialysis.

- **Physical Therapy** — the treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio–mechanical and neuro–physiological principles, and devices to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of body part.

- **Occupational Therapy** — treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role.

- **Speech Therapy** — treatment for the correction of a speech impairment resulting from disease, Surgery, injury, congenital and developmental anomalies, or previous therapeutic processes.

Total Disability (or Totally Disabled)

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

- The Subscriber is unable to perform the substantial duties of any occupation or business for which he/she is qualified and the Subscriber is not in fact engaged in any occupation for wages or profit; or

- If the Subscriber does not usually work for wages or profit, the Subscriber cannot do the normal activities of a person of the same age and sex.

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

Waiting Period

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

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved	01/30/2012

Comments:

Attachment:

Readability BCBSOK and AR ET.pdf

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved	01/30/2012

Bypass Reason: No policy is being submitted for this filing

Comments:

		Item Status:	Status Date:
Satisfied - Item:	PPACA Uniform Compliance Summary	Approved	01/30/2012

Comments:

Attachment:

OK PPACA Uniform Compliance Summary.pdf

		Item Status:	Status Date:
Satisfied - Item:	Authorization	Approved	01/30/2012

Comments:

Attachment:

HCSC Authorization to File.pdf

		Item Status:	Status Date:
Satisfied - Item:	OK Grandfathered HCR	Approved	01/30/2012

Comments:

Attachment:

OK Grandfathered HCR.pdf

		Item Status:	**Status Date:**
Satisfied - Item:	Certification of Benefit Differential	Approved	01/30/2012

Comments:

Attachment:

AR BCBSOK Certification of Benefit Differential.pdf

		Item Status:	**Status Date:**
Satisfied - Item:	AR_AR Certif of Compliance with Rule 19	Approved	01/30/2012

Comments:

Attachment:

AR_AR Certif of Compliance with Rule 19.pdf

		Item Status:	**Status Date:**
Satisfied - Item:	OK Non-grandfathered HCR	Approved	01/30/2012

Comments:

Attachment:

OK Non-grandfathered HCR.pdf

Health Care Service Corporation
300 E. Randolph Street
Chicago, IL 60601

READABILITY CERTIFICATION

To the best of our knowledge and ability we have determined the Flesch scale analysis readability test scores to be as shown:

Form Number	Flesch Score
CB-OK-CE with inserts	42.0
ETGB-AR-HCSC – 2012	40.0

By: _____

Scott Hilgeman

Title: Vice President and Chief Underwriter

PPACA Uniform Compliance Summary

Please select the appropriate check box below to indicate which product is amended by this filing.

☐ **INDIVIDUAL HEALTH BENEFIT PLANS** ***(Complete SECTION A only)***

☑ **SMALL / LARGE GROUP HEALTH BENEFIT PLANS** ***(Complete SECTION B only)***

This form filing compliance summary is to be submitted with your [endorsement][contract] to comply with the immediate market reform requirements of the Patient Protection and Affordable Care Act (PPACA). These PPACA requirements apply only to policies for health insurance coverage referred to as "major medical" in the statute, which is comprehensive health coverage that includes PPO and HMO coverage. This form includes the requirements for grandfathered (coverage in effect prior to March 23, 2010) and non-grandfathered plans, and relevant statutes. Refer to the relevant statute to ensure compliance. Complete each item to confirm that diligent consideration has been given to each. (*If submitting your filings electronically, bookmark the provision(s) in the form(s) that satisfy the requirement and identify the page/paragraph on this form.*)

***For all filings, include the Type of Insurance (TOI) in the first column.**

☐ Check box if this is a paper filing.

COMPANY INFORMATION

Company Name	NAIC Number	SERFF Tracking Number(s) *if applicable	Form Number(s) of Policy being endorsed	Rate Impact
Blue Cross and Blue Shield of Oklahoma TOI = H16G - Group Health - Major Medical	70670		GD-10-12G-PR OK HCSC	☐ Yes ☑ No

PPACA Uniform Compliance Summary

Reset Form

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	*[Sections 2704 and 1255 of the PHSA/Section 1201 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Eliminate Annual Dollar Limits on Essential Benefits Except allows for "restricted" annual dollar limits for essential benefits for plan years prior to January 1, 2014.	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Eliminate Lifetime Dollar Limits on Essential Benefits	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	*[Section 2712 of the PHSA/Section 1001 of PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services.	*[Section 2713 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26.	*[Section 2714 of the PHSA/Section 1001 of the PPACA]*	☐ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Appeals Process – Requires establishment of an internal claims appeal process and external review process.	*[Section 2719 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no,** please explain.
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child's PCP if the provider is in-network.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

Reset Form

SECTION B – Group Health Benefit Plans (Small and Large)

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	*[Sections 2704 of the PHSA/Section 1201 of the PPACA]*	☑ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation: Noted on attached amendment.			
	Page Number:			
	Eliminate Annual Dollar Limits on Essential Benefits – Except allows for "restricted" annual dollar limits for essential benefits for plan years prior to January 1, 2014.	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☑ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation: Noted on attached amendment.			
	Page Number:			
	Eliminate Lifetime Dollar Limits on Essential Benefits	*[Section 2711 of the PHSA/Section 1001 of the PPACA]*	☑ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no,** please explain.
	Explanation: Noted on attached amendment.			
	Page Number:			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	*[Section 2712 of the PHSA/Section 1001 of PPACA]*	☑ **Yes** ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation: Contained in existing Group Contract			
	Page Number: 7			

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services	*[Section 2713 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26. ◊	*[Section 2714 of the PHSA/Section 1001 of the PPACA]*	☑ **Yes**◊ ☐ No If **no**, please explain.	☐ **Yes** ☐ No If **no**, please explain.
	Explanation: Noted on attached amendment.			
	Page Number:			
	Appeals Process – Requires establishment of an internal claims appeal process and external review process.	*[Section 2719 of the PHSA/Section 1001 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			

◊ For plan years beginning before January 1, 2014, grandfathered group plans are not required to extend coverage to a child until the age of 26 if such child is eligible to enroll in another employee-sponsored plan

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	**Category**	**Statute Section**	**Grandfathered**	**Non-Grandfathered**
	Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child's PCP if the provider is in-network.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			
	Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.	*[Section 2719A of the PHSA/Section 10101 of the PPACA]*	N/A	☐ **Yes** ☐ No If **no**, please explain.
	Explanation:			
	Page Number:			

BlueCross BlueShield of Illinois

NAIC Company Code: 70670

Re: Group Medical Forms

To: All State Insurance Departments

Health Care Service Corporation, a Mutual Legal Reserve Company, which also does business as Blue Cross and Blue Shield of Illinois, Blue Cross Blue Shield of Texas, Blue Cross Blue Shield of Oklahoma and Blue Cross Blue Shield of New Mexico**,** hereby authorizes Compliance Research Services, LLC to represent us in the submission of the above-referenced forms and to negotiate with insurance departments for their approval.

Sincerely,

Health Care Service Corporation,
a Mutual Legal Reserve Company

Karen M. Atwood

Karen M. Atwood
Senior Vice President
National Accounts

BlueCross BlueShield
of Oklahoma

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

AMENDMENTS TO THE GROUP HEALTH PLAN

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

A. **AMENDMENT RESPECTING DEPENDENT ELIGIBILITY**

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

If the Group Health Plan contains provisions extending coverage for Dependents beyond their 26th birthday (e.g., for full-time students), then those provisions shall remain in effect. A Dependent child who is medically certified as disabled and dependent upon the Member or his/her spouse is eligible to continue coverage beyond the limiting age, provided the disability began before the child attained the age of 26.

B. **AMENDMENT RESPECTING PREEXISTING CONDITION PROVISIONS**

The Preexisting Condition provisions of the Group Health Plan are amended so that the Preexisting Condition Exclusion shall not apply to Subscribers under age 19.

C. **AMENDMENT RESPECTING LIFETIME MAXIMUMS**

The Lifetime Maximum set forth in the Schedule of Benefits, or in any amendment or endorsement to the Group Contract or Certificate of Benefits, is hereby deleted. Coverage under the Group Health Plan shall not be subject to any ***dollar*** Lifetime Maximum, including the separate ***dollar*** Lifetime Maximum previously applicable for treatment of autism and autism spectrum disorders.

D. **AMENDMENT RESPECTING BENEFIT PERIOD MAXIMUMS**

The Benefit Period ***dollar*** maximums shown in the Schedule of Benefits, Covered Comprehensive Health Care Services section or in any amendment or endorsement issued thereto are amended as set forth below:

1. Preventive Care Services — Any Benefit Period ***dollar*** maximum specified for Preventive Care Services shall no longer apply. This includes any separate ***dollar*** maximum applicable to mammography screening, bone density testing or prostate cancer screening.
2. Private Duty Nursing — Covered Services shall be limited to a maximum of 85 visits per Benefit Period. The Benefit Period ***dollar*** maximum is hereby removed.
3. Hospice Services — The Benefit Period ***dollar*** maximum is hereby removed.
4. Durable Medical Equipment — The Benefit Period ***dollar*** maximum is hereby removed.

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5. Prosthetic Appliances — The Benefit Period ***dollar*** maximum is hereby removed.
6. Services Related to Treatment of Autism or Autism Spectrum Disorders — The Benefit Period ***dollar*** maximum is hereby removed. The age limit for treatment of autism or autism spectrum disorders is hereby removed. The following limitations shall apply:
   - **Subscribers under age six** shall be entitled to a combined maximum of 390 visits for Physical Therapy, Occupational Therapy and Speech Therapy per Benefit Period.
   - Subscribers age six and older are subject to the limitations specified under "**Outpatient Therapy Services**" as set forth in the ***Comprehensive Health Care Services*** section of this Certificate. No Benefits are provided for Outpatient Speech Therapy.

   Other Covered Services, as specified in the Contract, Certificate or in any amendment issued thereto, related to treatment of autism or autism spectrum disorders shall not be subject to a Benefit Period maximum.

E. **AMENDMENT RESPECTING TREATMENT OF AUTISM AND AUTISM SPECTRUM DISORDERS**

Benefits for the treatment of autism and autism spectrum disorders shall no longer be limited to Subscribers under age six. However, such treatment shall be subject to the Preexisting Condition limitations of the Group Health Plan (except for Subscribers under age 19), the limitations set forth in Paragraph D, 6, above, and any other limitations set forth in the Contract/Certificate and any amendments attached thereto.

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

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status may be directed to the Employer or Group Administrator.

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

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

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

The effective date of this amendment is the first Contract Date Anniversary after September 23, 2010.

President of Blue Cross and Blue Shield of Oklahoma

STATE OF ARKANSAS

CERTIFICATION OF COMPLIANCE

Company Name: Health Care Service Corporation

Form Numbers:

CB-OK-CE et al	Oklahoma Certificate
CB-OK-IN-BC	BlueChoice Certificate Insert
CB-OK-IN-BC-NO	BlueChoice Certificate Insert
CB-OK-IN-BP	BluePreferred Certificate Insert
CB-OK-IN-BO	BlueOptions Certificate Insert
CB−OK−IN−BZ	BlueOptimize Certificate Insert
CB-OK-IN-BT	BlueTraditional Certificate Insert
ETGB-AR-HCSC-2012	Arkansas Rider
HCR-GF-GP-1210	Health Care Reform Rider (Grandfathered plans)
HCR-NGF-GP-1210	Health Care Reform Rider (Non-Grandfathered plans)

I hereby certify that to the best of my knowledge and belief, the above forms and submission comply with Arkansas Insurance Bulletin 9-85, in that the differential of benefits between PPO and non-PPO providers does not exceed 25%.

Scott Hilgeman
Vice President and Chief Underwriter

January 13, 2012
Date

Insurer: Health Care Service Corporation, a Mutual Legal Reserve Company

Form Number(s):		
	CB-OK-CE et al	Oklahoma Certificate
	CB-OK-IN-BC	BlueChoice Certificate Insert
	CB-OK-IN-BC-NO	BlueChoice Certificate Insert
	CB-OK-IN-BP	BluePreferred Certificate Insert
	CB-OK-IN-BO	BlueOptions Certificate Insert
	CB−OK−IN−BZ	BlueOptimize Certificate Insert
	CB-OK-IN-BT	BlueTraditional Certificate Insert
	ETGB-AR-HCSC-2012	Arkansas Rider
	HCR-GF-GP-1210	Health Care Reform Rider (Grandfathered plans)
	HCR-NGF-GP-1210	Health Care Reform Rider (Non-Grandfathered plans)

Signature of Company Officer

Scott Hilgeman
Name

Vice President and Chief Underwriter

Title

January 13, 2012
Date

BlueCross BlueShield
of Oklahoma

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

AMENDMENTS TO THE GROUP HEALTH PLAN

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

A. AMENDMENT RESPECTING DEPENDENT ELIGIBILITY

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

If the Group Health Plan contains provisions extending coverage for Dependents beyond their 26th birthday (e.g., for full-time students), then those provisions shall remain in effect. A Dependent child who is medically certified as disabled and dependent upon the Member or his/her spouse is eligible to continue coverage beyond the limiting age, provided the disability began before the child attained the age of 26.

B. AMENDMENT RESPECTING PREEXISTING CONDITION PROVISIONS

The Preexisting Condition provisions of the Group Health Plan are amended so that the Preexisting Condition Exclusion shall not apply to Subscribers under age 19.

C. AMENDMENT RESPECTING LIFETIME MAXIMUMS

The Lifetime Maximum set forth in the Schedule of Benefits, or in any amendment or endorsement to the Group Contract or Certificate of Benefits, is hereby deleted. Coverage under the Group Health Plan shall not be subject to any ***dollar*** Lifetime Maximum, including the separate ***dollar*** Lifetime Maximum previously applicable for treatment of autism and autism spectrum disorders.

D. AMENDMENT RESPECTING BENEFIT PERIOD MAXIMUMS

The Benefit Period ***dollar*** maximums shown in the Schedule of Benefits, Covered Comprehensive Health Care Services section or in any amendment or endorsement issued thereto are amended as set forth below:

1. Preventive Care Services — Any Benefit Period ***dollar*** maximum specified for Preventive Care Services shall no longer apply. This includes any separate ***dollar*** maximum applicable to mammography screening, bone density testing or prostate cancer screening.

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®Registered Marks Blue Cross and Blue Shield Association.

2. Private Duty Nursing — Covered Services shall be limited to a maximum of 85 visits per Benefit Period. The Benefit Period ***dollar*** maximum is hereby removed.
3. Hospice Services — The Benefit Period ***dollar*** maximum is hereby removed.
4. Durable Medical Equipment — The Benefit Period ***dollar*** maximum is hereby removed.
5. Prosthetic Appliances — The Benefit Period ***dollar*** maximum is hereby removed.
6. Services Related to Treatment of Autism or Autism Spectrum Disorders — The Benefit Period ***dollar*** maximum is hereby removed. The age limit for treatment of autism or autism spectrum disorders is hereby removed. The following limitations shall apply:
   - **Subscribers under age six** shall be entitled to a combined maximum of 390 visits for Physical Therapy, Occupational Therapy and Speech Therapy per Benefit Period.
   - Subscribers age six and older are subject to the limitations specified under "**Outpatient Therapy Services**" as set forth in the ***Comprehensive Health Care Services*** section of this Certificate. No Benefits are provided for Outpatient Speech Therapy.

   Other Covered Services, as specified in the Contract, Certificate or in any amendment issued thereto, related to treatment of autism or autism spectrum disorders shall not be subject to a Benefit Period maximum.

E. AMENDMENT RESPECTING EMERGENCY CARE SERVICES

Emergency Care Services rendered by an Out-of-Network or Non-Participating Provider shall be paid at the same Benefit level applicable to Network/Participating Providers. Any Benefit reductions for Out-of-Network Services in the form of higher Deductibles, Copayments and/or Coinsurance are hereby removed.

Notwithstanding anything in the Contract/Certificate to the contrary, for Out-of-Network Emergency Care Services rendered by non-contracting Providers, the Allowable Charge shall be equal to the greatest of the following three possible amounts—not to exceed billed charges:

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

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

F. AMENDMENT RESPECTING PREVENTIVE CARE SERVICES

Benefits will be provided for the following Covered Services, and network Provider services will not be subject to Deductible, Copayment, Coinsurance or dollar maximums:

1. evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF");
2. immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved;

3. evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") for infants, children, and adolescents; and
4. with respect to women, such additional preventive care and screenings, not described in item 1 above, as provided for in comprehensive guidelines supported by the HRSA.

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

The Preventive Care Services described in items 1 through 4 above may change as USPSTF, CDC and HRSA guidelines are modified. For more information, Subscribers may access the website at www.bcbsok.com or contact customer service at the toll-free number listed on their identification card.

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

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

Covered Services ***not*** included in items 1 through 4 above may be subject to Copayment, Deductible, Coinsurance and/or dollar maximums.

Covered Preventive Care Services received from Out-of-Network Providers may be subject to Copayment, Deductible and 30% Coinsurance.

The Exclusions section is amended so that any exclusion for "routine, screening or periodic physical examinations" shall not be applicable to the Preventive Care Services described above.

G. AMENDMENT RESPECTING TREATMENT OF AUTISM AND AUTISM SPECTRUM DISORDERS

Benefits for the treatment of autism and autism spectrum disorders shall no longer be limited to Subscribers under age six. However, such treatment shall be subject to the Preexisting Condition limitations of the Group Health Plan (except for Subscribers under age 19), the limitations set forth in Paragraph D, 6, above, and any other limitations set forth in the Contract/Certificate and any amendments attached thereto.

H. AMENDMENT RESPECTING MEMBER APPEAL RIGHTS

The External Review (Level III) appeals process is amended by the addition of the following provisions:

For questions or assistance regarding the right to an external review by an independent review organization, the Member may call the customer service number shown on the Identification Card. Members may also contact the Oklahoma Insurance Department at the following address:

Oklahoma Insurance Department
P.O. Box 53408
Oklahoma City, OK 73152-3408
1-800-522-0071 (Oklahoma only)
405-521-2991

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

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

For Contracts in effect on or after September 23, 2010, this amendment is effective on the Group Contract Date or Contract Date Anniversary.

President of Blue Cross and Blue Shield of Oklahoma