The University of Oklahoma
Self-Funded Student Health Plan
Norman Campus and Health Sciences Center Campus
2022 – 2023 Academic Year

Administered by:

Blue Cross and Blue Shield of Oklahoma

(BCBSOK)

Please read this Plan Document to understand your coverage.

Blue Cross Blue Shield of Oklahoma

Account Number:

Medical: 115548-15

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Introduction

The University of Oklahoma sponsors this self-funded Student Health Plan (Plan), administered by Blue Cross and Blue Shield of Oklahoma and Academic HealthPlans (AHP). This Plan Document explains your health care benefits, including what health care services are covered and how to use the benefits. This Plan provides benefits to Covered Students and their Covered Dependents on or off campus for weekends, holidays, summer vacations, at home or while traveling 24 hours per day for the Plan year. This Plan meets the requirements of the Affordable Care Act (ACA). The Plan has an actuarial value which meets or exceeds a gold metal level of coverage. This Plan will always pay benefits in accordance with any applicable federal and Oklahoma state insurance law(s).

Keep these fundamental features in mind as you learn about this Plan:

- **This Student Health Plan is a Participating Provider Organization (PPO) plan.** You should seek treatment from the BCBSOK BlueChoice® Participating Provider Organization (PPO) Network, which consists of hospitals, doctors, ancillary, and other health care providers who have contracted with BCBSOK for the purpose of delivering covered health care services at negotiated prices, so you can maximize your benefits under this Plan. A list of network providers can be found online at ***ou.myahpcare.com*** or by calling **(855) 267-0214**. Using BCBSOK providers may save you money.

- **Greater benefits are available for care received from Goddard Health Center, OU Physicians Student Health & Wellness Clinic, or Schusterman Student Health Clinic.**

- **Participation in Plan does not mean all of your health care costs are paid in full by the Plan.** There are several areas for which you could be responsible for payment, including, but not limited to, a Deductible, a Copayment or Coinsurance (patient percentage of Covered Medical Expenses), and medical costs for services excluded by the Plan.

- **It is your responsibility to familiarize yourself with this Plan.** Exclusions and limitations are applied to the coverage as a means of cost containment. To make this coverage work for you, it is helpful to be informed and proactive. Check the covered benefits in this Plan Document before seeking care whenever possible. Know the specifics and communicate them to your health care provider.

Benefit and Eligibility Questions
Representatives from AHP and BCBSOK are available to answer your questions. You may contact AHP at **(855) 924-7758** for enrollment and eligibility questions and BCBSOK at **(855) 267-0214** for benefit and claim questions.

Please Note: We have capitalized certain terms that have specific, detailed meanings, which are important to help you understand your Plan. The meaning of some of these terms may not be evident from the context in which they are used. Many have been defined in the Definitions section of this document.

Privacy Notice

We know that your privacy is important to you and we strive to protect the confidentiality of our personal health information. Under the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA), we are required to provide you with notice of our legal duties and privacy practices with respect to personal health information. You will receive a copy of the HIPAA Notice of Privacy Practices upon request. Please write to Academic HealthPlans, Inc., P.O. Box 1605, Colleyville, TX 76034-1605, or call (817) 809-4700, or you may view and download a copy from the website at **ou.myahpcare.com** or **ouhsc.myahpcare.com**.

Eligibility

HSC students: As part of the acceptance criteria at the University of Oklahoma Health Sciences Center, all HSC students are required to have medical coverage, including coverage for exposure to bloodborne pathogens. The University requires each active student to show proof of ACA Compliant health insurance coverage and coverage for exposure to bloodborne pathogens.

Undergraduate students: You must be enrolled for at least nine (9) credit hours during the fall or spring semesters or three (3) credit hours if you are enrolling for summer only coverage. If you are in your last semester before graduation and you need fewer than nine (9) hours, you may continue to have coverage. (You have this option only once during your attendance at OU.)

Graduate students: You must be enrolled for five (5) credit hours during the fall or spring semesters, three (3) credit hours if you are enrolling for summer only coverage, or two thesis or dissertation credit hours. If you are in your last semester before taking your thesis or dissertation, and you need fewer than five (5) credit hours, you may continue to have coverage. (You have this option only once during your attendance at OU.)

Graduate Assistants: All Graduate Assistants who meet the eligibility requirements are automatically enrolled in the student health plan and are covered during the entire time of their appointment. Graduate Assistants who graduate in May are covered through the end of the academic plan year in August.

Disabled students: If you are not enrolled as a full-time student, but you have a documented disability and have successfully petitioned the university for full-time status, you may be eligible to enroll in the Plan.

Medical Leave of Absence (LOA): Covered Students may continue coverage through the end of the coverage period even if they are not actively attending classes if their department or program has granted them a Medical Leave of Absence. Students who have disenrolled from classes without an approved Medical Leave of Absence and no longer meet the minimum eligibility requirements for coverage will not be allowed to continue enrollment even if they have withdrawn for medical or health reasons. Graduate Assistants must have a letter from their department approving their medical LOA. All other students, including HSC students, must have a letter from their school/college approving their medical LOA.

International students (Norman Campus): Non-immigrant international students (on an "F" visa or "J-1" visa) taking credit hours are automatically enrolled unless a waiver is granted. Center for English as a Second Language (CESL) students are also automatically enrolled unless a waiver is granted.

Other students: Students specifically designated by the university may be eligible for the plan.

All students: A student must actively attend classes in accordance with the student's academic program for at least the first 31 days after the date for which coverage is purchased unless he or she withdraws from classes due to an Injury or Sickness and the absence is an approved Medical Leave of Absence (LOA).

Distance learning classes (home study, correspondence, Internet classes and television (TV) courses) do not fulfill the eligibility requirements, unless the student is in full accordance with their campus based academic program and is enrolled in at least one campus-based class. The Plan maintains its right to investigate student status and attendance records to verify that the eligibility requirements have been met. If the Plan discovers the eligibility requirements have not been met, its only obligation is refund of Premium. Coverage will be terminated as of the date you are no longer enrolled in classes. Domestic and International students returning in the fall (or graduating during the year in which they purchase coverage) may maintain coverage throughout the summer months even if they are not enrolled in summer classes.

Eligible students who enroll may also cover their Dependents. Dependent enrollment must take place at the time of student enrollment (or within 30 days if tuition billed) with the exception of newborn or adopted children or a Qualifying Event. Dependent means a Covered Student's lawful spouse or a Covered Student's child, stepchild, foster child, a child who is adopted by the Covered Student or placed for adoption with the Covered Student, or for which the Covered Student is a party in a suit for the adoption of the child; or a child which the Covered Student is required to cover under a medical support order issued or enforceable by the courts. Any such child must be under age 26.

Coverage will continue for a child who is 26 or more years old, chiefly supported by the Covered Student and incapable of self-sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to the claim administrator, BCBSOK, within 31 days after the date the child ceases to qualify as a child for the reasons listed above. During the next two years, BCBSOK may, from time to time, request proof of the continuation of such condition and dependence. After that, BCBSOK may request proof no more than once a year.

Dependent coverage is available only if the student is also covered. Dependent coverage must be the exact same coverage period of the Covered Student; and therefore, will expire concurrently, with that of the student.

A newborn child will automatically be covered for the first 31 days following the child's birth. To extend coverage for a newborn child past the 31-day period, the covered student must: 1) enroll the child within 31 days of birth, and 2) pay any required additional Premium.

Student Athletes: Student Athletes are eligible for coverage under this Student Health Plan. If a Student Athlete is covered under another health plan designed to cover Injury or Illness associated with his or her participation in an athletics program (such as the coverage sponsored by the National Collegiate Athletic

Association (NCAA)) this Student Health Plan will be secondary to any coverage or benefits provided by the Student Athlete's athletics program coverage.

Qualifying Events

Eligible students who have a change in status and lose coverage under another Health Care Plan are eligible to enroll for coverage under the Plan, within 31 days of the Qualifying Event. Students are required to submit the Qualifying Event enrollment form, a copy of the Certificate of Creditable Coverage, and the letter of ineligibility. A change in status due to a qualifying event includes, but is not limited to, loss of a spouse, whether by death, divorce, annulment, or legal separation. The Premium will be the same as it would have been at the beginning of the semester or quarter, whichever applies. However, the effective date will be the later of the date the student enrolls for coverage under the Plan and pays the required Premium, or the day after the prior coverage ends. You may download the forms from **ou.myahpcare.com** or **ouhsc.myahpcare.com**.

Effective Dates and Termination

The Plan coverage becomes effective at 12:00 a.m. standard time at the University's address on the later of the following dates:

1) The effective date of the Plan,
2) The date Premium is paid by the student, or
3) The date the eligibility requirements are met.

Coverage is effective as follows:

HEALTH SCIENCES CENTER CAMPUS	From	Through
Fall 1	07/01/22	12/31/22
Fall 2	08/15/22	12/31/22
Spring	01/01/23	05/31/23
Spring/Summer	01/01/23	06/30/23
Summer	06/01/23	06/30/23

NORMAN CAMPUS	From	Through
Annual	08/19/22	08/18/23
Fall	08/19/22	01/16/23
Spring	01/17/23	05/14/23
Spring/Summer*	01/17/23	08/18/23
Summer	05/15/23	08/18/23

**F-1 Internationals are required to enroll in Spring/Summer coverage for the Spring Semester.*

CESL STUDENTS	From	Through
Fall 1	08/19/22	10/16/22
Fall 2	10/17/22	01/17/23
Spring 1	01/18/23	03/20/23
Spring 2	03/21/23	05/11/23
Summer 1	05/12/23	06/29/23
Summer 2	06/30/23	08/18/23

The coverage provided with respect to the Covered Person shall terminate at 11:59 p.m. standard time on the earliest of the following dates:

1. The last day of the Coverage Period through which the Premium is paid, or
2. The last day of the month in which eligibility requirements are no longer met.

You must meet the eligibility requirements listed herein each time you pay a Premium to continue coverage. To avoid a lapse in coverage, your Premium must be received within 31 days after the coverage expiration date. It is the student's responsibility to make timely Premium payments to avoid a lapse in coverage. **Refunds of Premium are allowed only if the administrator discovers eligibility requirements have not been met or upon entry into the Armed Forces, and the administrator receives proof of active duty. Otherwise, all Premiums received by the administrator will be nonrefundable.**

Your eligibility for coverage under this Plan is determined entirely by your status as a student at the University of Oklahoma. Your coverage will remain in effect (except in cases of fraud) for a chosen Coverage Period (annual, fall semester, spring semester, etc.) as long as you have paid any required Premiums, and you meet the minimum Plan eligibility requirements as a student. You may enroll in subsequent Coverage Periods as long as you maintain the minimum eligibility requirements as a student and pay any required Premium. It is the Covered Person's responsibility to enroll for coverage each year in order to maintain continuity of coverage. If you no longer meet the eligibility requirements contact Academic HealthPlans at 1-888-924-7758 prior to your termination date.

Extension of Benefits

The coverage provided under the plan ceases on the termination date. However, if a Covered Person is Hospital Confined, on the termination date for a covered Injury or Sickness for which benefits were paid before the termination date, the Covered Expenses for such covered Injury or Sickness will continue to be paid provided the condition continues but not to exceed 90 days after the termination date.

The total payments made in respect of the Covered Person for such condition both before and after the termination date will never exceed the maximum benefit. After this "Extension of Benefits" provision has been exhausted, all benefits cease to exist, and under no circumstances will further payments be made.

Coordination of Benefits

Under a Coordination of Benefits (COB) provision, the plan that pays first is called the Primary Plan. The Secondary Plan typically makes up the difference between the Primary Plan's benefit and the Covered Expenses. When one plan does not have a COB provision, that plan is always considered Primary, and

always pays first. You may still be responsible for applicable Deductible amounts, Copayments and Coinsurance. When Student Athletes have coverage under a health care plan associated with their participation in any athletics program, such as plans sponsored by the NCAA, the coverage associated with the student's athletics program participation will be considered the Primary Plan, and this Student Health Plan will be considered the Secondary Plan.

Outpatient Prescription Drug Benefit

AT THE OU STUDENT HEALTH CENTER ONLY: Expenses are payable at 100% of the Allowable Charge after a $15 Copayment for each Generic and a $50 Copayment for each Brand Name prescription drug dispensed by Goddard Health Center (Norman Campus), OU Physicians Student Health & Wellness Clinic (OKC) or Student Health Clinic (Tulsa Campus). *Note: All contraceptives will be covered at 100% with no Copayments at the health centers.*

AT PHARMACIES CONTRACTING WITH THE PRIME THERAPEUTICS NETWORK: After the $100 prescription drug Deductible has been satisfied, expenses are payable at 100% of the Allowable Charge after a $15 Copayment for each Generic and a $50 Copayment for each Brand Name prescription drug dispensed by a pharmacy contracting with the Prime Therapeutics Network. Benefits include diabetic supplies. You must go to a pharmacy contracting with the Prime Therapeutics Network in order to access this program. Present your insurance ID card to the pharmacy to identify yourself as a participant in this Plan. Eligibility status will be online at the pharmacy. You can locate a participating pharmacy by calling (800) 423-1973 or online at **ou.myahpcare**.com or **ouhsc.myahpcare.com**.

Covered Expenses for all prescription drugs are limited to a 90-day supply/one (1) Copayment per 30 days.

Pre-Authorization Notification

BCBSOK should be notified of all Hospital Confinements prior to admission.

1. **Pre-Authorization Notification of Medical Non-Emergency Hospitalizations:** The patient, Doctor or Hospital should telephone (800) 441-9188 at least five (5) working days prior to the planned admission.
2. **Pre-Authorization Notification of Medical Emergency Hospitalizations:** The patient, patient's representative, Doctor or Hospital should telephone (800) 441-9188 within two (2) working days of the admission or as soon as reasonably possible to provide the notification of any admission due to Medical Emergency.

BCBSOK is open for Pre-Authorization Notification calls from 8:00 a.m. to 6:00 p.m., C.S.T., Monday through Friday. Calls may be left on the Customer Service Department's voicemail after hours by calling (800) 441-9188. **IMPORTANT:** Failure to follow the notification procedures will not affect benefits otherwise payable under the Plan; in addition, Pre-Authorization Notification is not a guarantee that benefits will be paid.

Overview of the Student Health Plan

The Plan covers many medical services available at the on-campus Student Health Center. The Student Health Plan also pays for many services not available at the Health Center. This plan helps make medical care more affordable, because they include a network of medical providers—called the Preferred Provider Organization (PPO)—that have agreed to charge reduced rates for medical care to people covered under the Student Health Plan.

Choosing a Health Care Provider

The Student Health Plan provides benefits for Covered Medical Care provided by the Student Health Center and other medical service providers. To get the greatest benefit from your medical plan, it is important to understand when to use each kind of provider.

- **Student Health Center:** When you need medical care, you should start by going to the Student Health Center. They will refer you to another provider if they cannot provide the services you need.

  Student Health Clinic: (918) 660-3102, 4502 East 41st Street, Room 1C76, Tulsa, OK

  OU Physicians Student Health & Wellness Clinic: (405) 271-2577, 825 NE 10th Street, OKC, OK

  Goddard Health Center: (405) 325-4441, 620 Elm Ave., Norman, OK

- **Preferred Providers:** The Preferred Provider Organization (PPO) is a network of Doctors, Hospitals and other health care providers who have agreed to provide medical care at discounted rates to students and their dependents covered under the Student Health Plan. The Student Health Plan pays a greater percentage of Covered Medical Care when you use Network Provider Doctors and Hospitals than it pays for Out-of-Network Doctors. To receive the PPO benefit level, you must first receive a valid written referral from the Student Health Center. If you are admitted to a PPO Hospital, please be aware that not all of the Doctors at the that Hospital are necessarily part of the PPO. Whenever you receive a referral to any provider, it is your responsibility to verify that the provider is part of the PPO. No referral is required to receive the PPO benefit level for obstetrical, gynecological, or pediatric care.

  Out-of-Network Providers: You should generally use only the Student Health Center or PPO Network Providers. If you use Out-of-Network Providers you will have limited coverage, and the plan will pay a lower percentage of the cost of Covered Medical Care. Also, if your provider's charges are more than the Allowable Charge, you must pay 100% of any charges that exceed the Allowable Charge.

What the Plan Covers

The Schedule of Benefits provides an overview of how the Student Health Plan pays for Covered Medical Care. You need to be aware that the Student Health Plan has certain limitations and exclusions.

Receiving Medical Care from the Student Health Center (SHC)

1. **Visit the Student Health Center First** (See above for locations)

2. **Get a Referral** - If the Student Health Center cannot provide the services you need, they will refer you to a Preferred Provider. You must get a referral from the Student Health Center before you visit any other provider unless you are out of town or require emergency care in a Hospital Emergency Room when the center is closed. A referral is not needed for any obstetrical, gynecological, or pediatric care.

Receiving Medical Care When the Student Health Center is Closed

(A referral is still required within 48 hours.)

1. **Go to the Urgent Care** - When the Student Health Center is closed you may go to an Urgent Care Center. Urgent care is for treatment of a medical condition needing immediate attention. According to the Urgent Care Association of America, urgent care services often serve as a direct link between the public and Emergency Room services. Examples could include care for flu, lacerations, stitches, animal bites and so forth.

2. **Go to the Emergency Room** - You should only visit a Hospital Emergency Room when the Sickness or Injury could cause serious jeopardy to your health if not immediately treated.

3. **Get a Referral** - You must contact the Student Health Center to get a referral within two (2) days after your visit to another provider. Benefits will be reduced if you fail to receive a referral from the Student Health Center within 48 hours. A referral is not needed for any obstetrical, gynecological, or pediatric care.

Schedule of Benefits

	OU Physicians Student Health & Wellness Clinic (OKC) Student Health Clinic (Tulsa) Goddard Health Center (Norman)	**In and Out-of-Network Providers** (with Referral)	**In and Out-of-Network Providers** (without Referral)
COINSURANCE	100%	80%*	60%*
PLAN DEDUCTIBLE*	$0	$500	$1,500
OUT-OF-POCKET MAXIMUM (Unless otherwise noted)	No Maximum	$6,600 in Network individual $13,200 In Network Family	$15,000 Out-of-Network Per Person

***After the Deductible is satisfied, benefits will be paid based on the selected provider. Benefits will be paid at 80% of the Allowable Charge for services rendered by Network Providers in the Blue Cross and Blue Shield of Oklahoma (BCBSOK) BlueChoice® PPO Network, unless otherwise specified in the Plan. Services obtained from Out-of-Network Providers (any provider outside the BCBSOK BlueChoice® PPO Network) will be paid at 60% of the Allowable Charge, unless otherwise specified in the Plan. Benefits will be paid up to the maximum for each service as specified below regardless of the provider selected.**

OUT-OF-POCKET MAXIMUM: Once the Out-of-Pocket limit has been satisfied, Covered Expenses will be payable at 100% for the remainder of the Plan year, up to any maximum that may apply. Coinsurance applies to the Out-of-Pocket limit. Covered Expenses are:

Inpatient *Plan Deductible Applies	**OU Physicians Student Health & Wellness Clinic (OKC) Student Health Clinic (Tulsa) Goddard Health Center (Norman)**	**In and Out-of-Network Providers** (with Referral)	**In and Out-of-Network Providers** (without Referral)
Hospital Expense: Daily semi-private room rate; intensive care; general nursing care provided by the Hospital; Hospital Miscellaneous Expenses such as the cost of the operating room, Laboratory tests, X-ray examinations, preadmission testing, anesthesia, drugs (excluding take home drugs) or medicines, Physical Therapy, Occupational and Speech therapy, therapeutic services and supplies.	N/A	80% of Allowable Charge*	60% of Allowable Charge*
Surgical Expense: Student Health Center, Minor Office Surgery Only Network and Out-of-Network Provider, when multiple surgical procedures are performed during the same operative session, the primary or major procedure is eligible for full allowance for that procedure. The surgical procedure with the highest Allowable Charge should be priced at 100% of the Allowable Charge and the remaining eligible procedures should be priced at 50% of the Allowable Charge.	100% Minor Office Surgery Only	80% of Allowable Charge*	60% of Allowable Charge*

Outpatient *Plan Deductible Applies	**OU Physicians Student Health & Wellness Clinic (OKC) Student Health Clinic (Tulsa) Goddard Health Center (Norman)**	**In and Out-of-Network Providers** (with Referral)	**In and Out-of-Network Providers** (without Referral)
Assistant Surgeon	N/A	80% of Allowable Charge*	60% of Allowable Charge*
Anesthetist	N/A	80% of Allowable Charge*	60% of Allowable Charge*
Routine Well-Baby Care	N/A	80% of Allowable Charge*	60% of Allowable Charge*
Mental & Nervous Disorder/Alcoholism & Drug Abuse (Office Visits other than counseling)	100%	$35 Office Visit Copay, All other services 80% of Allowable Charge*	60% of Allowable Charge*
Mental & Nervous Disorder / Alcoholism & Drug Abuse (Counseling Services), includes all related or ancillary charges incurred as a result of a Mental & Nervous Disorder.	100%	$35 Office Visit Copay, All other services 80% of Allowable Charge*	60% of Allowable Charge*
Mental & Nervous Disorder/Alcoholism & Drug Abuse (All other services)	100%	$35 Office Visit Copay, All other services 80% of Allowable Charge*	60% of Allowable Charge*
Surgical Expense: Student Health Center, Minor Office Surgery Only Network and Out-of-Network Provider, when multiple surgical procedures are performed during the same operative session, the primary or major procedure is eligible for full allowance for that procedure. The surgical procedure with the highest Allowable Charge should be priced at 100% of the Allowable Charge and the remaining eligible procedures should be priced at 50% of the Allowable Charge.	100% Minor Office Surgery Only	80% of Allowable Charge*	60% of Allowable Charge*

Outpatient *Plan Deductible Applies	**OU Physicians Student Health & Wellness Clinic (OKC) Student Health Clinic (Tulsa) Goddard Health Center (Norman)**	**In and Out-of-Network Providers** (with Referral)	**In and Out-of-Network Providers** (without Referral)
Day Surgery Miscellaneous (Ambulatory Surgical Center Benefits), related to scheduled surgery performed in a Hospital, including the cost of the operating room, Laboratory tests, X-ray examinations, including professional fees, anesthesia, drugs or medicines and supplies. (Facility Charges Only)	N/A	80% of Allowable Charge*	60% of Allowable Charge*
Assistant Surgeon	N/A	80% of Allowable Charge*	60% of Allowable Charge*
Anesthetist	N/A	80% of Allowable Charge*	60% of Allowable Charge*
Primary Care Physician Office Visit	100%	$35 Copay	60% of Allowable Charge after Deductible
Specialist Office Visit	N/A	$50 Copay	60% of Allowable Charge after Deductible
Physical Therapy	100%	80% of Allowable Charge*	Not Covered
Chiropractic	N/A	80% of Allowable Charge*	Not Covered
Radiation Therapy and Chemotherapy	N/A	80% of Allowable Charge*	Not Covered

Outpatient *Plan Deductible Applies	**OU Physicians Student Health & Wellness Clinic (OKC) Student Health Clinic (Tulsa) Goddard Health Center (Norman)**	**In and Out-of-Network Providers** (with Referral)	**In and Out-of-Network Providers** (without Referral)
Emergency Room Expenses, benefits are payable for the use of the Emergency Room & Supplies. Copayment waived if admitted to the Hospital.	N/A	80% after $150 Copayment per visit *	80% after $150 Copayment per visit *
Minor Emergency/Urgent Care	N/A	100% Allowable Charge after a $60 Copayment per visit	60% after Deductible
Diagnostic X-rays & Laboratory Procedures	N/A	80% of Allowable Charge*	Not Covered
X-rays & Laboratory Services	100%	80% of Allowable Charge*	Not Covered
Injections, when administered in the Doctor's office and charged on the Doctor's statement	N/A	80% of Allowable Charge*	60% of Allowable Charge*
Tests & Procedures, diagnostic services and medical procedures performed by a Doctor, other than Doctor's Visits, Physical Therapy and X-rays and Lab procedures.	N/A	80% of Allowable Charge*	Not Covered
Prescription Drugs, all prescriptions are limited to 90 day retail supply with one Copayment per 30 days. Includes diabetic supplies. Specialty drugs are limited to a 30 day supply. *(See Outpatient Prescription Drug Section for more details.)*	100% of Allowable Charge after a $15 Copayment per Generic Drugs $50 Copayment per Brand Name Drugs $15/$50 Copayment per Specialty Drugs Contraceptives are paid at 100% *(No Copayment)*	***At pharmacies contracting with the Prime Therapeutics Network*** 100% of Allowable Charge after a $15 Copayment per Generic Drugs, $50 Copayment per Brand Name Drugs, $15/$50 Copayment per Specialty Drugs $100 Annual Prescription Deductible	Not Covered

The relationship between Blue Cross and Blue Shield of Oklahoma (BCBSOK) and contracting pharmacies is that of independent contractors, contracted through a related company, Prime Therapeutics, LLC. Prime Therapeutics also administers the pharmacy benefit program. BCBSOK, as well as several other independent Blue Cross plans, has an ownership interest in Prime Therapeutics.

Other	OU Physicians Student Health & Wellness Clinic (OKC) Student Health Clinic (Tulsa) Goddard Health Center (Norman)	In and Out-of-Network Providers (with Referral)	In and Out-of-Network Providers (without Referral)
Ambulance Service (deductible does not apply)	N/A	80% of Allowable Charge	80% of Allowable Charge
Durable Medical Equipment, when prescribed by a Doctor and a written prescription accompanies the claim when submitted.	N/A	80% of Allowable Charge*	60% of Allowable Charge*
Dental, made necessary by injury to sound, natural teeth only.	N/A	80% of Allowable Charge*	Not covered
Human Tissue and Organ Transplants	N/A	80% of Allowable Charge*	Not covered
Maternity/Complications of Pregnancy	N/A	$35 Copayment/ Visit	60% of Allowable Charge*
Preventative Care Services a. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventative Services Task Force ("USPSTF"); b. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC"); c. Evidenced-informed preventative care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") for infants, child(ren), and adolescents; and	100% of Allowable Charge	100% (for services not offered at the Student Health Center)	Not Covered
Other	**OU Physicians Student Health & Wellness Clinic (OKC)**	**In and Out-of-Network Providers** (with Referral)	**In and Out-of-Network Providers**

	Student Health Clinic (Tulsa) Goddard Health Center (Norman)		(without Referral)
d. With respect to women, such additional preventative care and screenings, not described in item "a" above, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) (https://www.hrsa.gov/womens-guidelines/index.html). Preventative Care services as mandated by state and federal law. Please refer to the Plan Document or call Blue Cross and Blue Shield of Oklahoma for more information at (855) 267-0214.	100% of Allowable Charge	100% (for services not offered at the Student Health Center	Not covered
Allergy Injections and Testing	N/A	80% of Allowable Charge*	60% of Allowable Charge*
Bone Density Testing as a diagnostic exam are subject to all of the provisions and limitations of the Plan.	N/A	80% of Allowable Charge*	Not covered
Skilled Nursing Facility Benefits	N/A	80% of Allowable Charge*	Not covered
Audiological services and hearing aids, limited to: One hearing aide per ear every 48 months and up to four additional ear molds for Covered Persons up to two years of age.	N/A	80% of Allowable Charge*	Not covered
Rehabilitative/Habilitative Outpatient Therapy Services: Benefits for Outpatient Physical Therapy Outpatient: Occupational Therapy and muscle manipulations/spinal subluxations.	N/A	80% of Allowable Charge*	Not covered
Other	**OU Physicians Student Health & Wellness Clinic (OKC) Student Health Clinic (Tulsa) Goddard Health Center (Norman)**	**In and Out-of-Network Providers** (with Referral)	**In and Out-of-Network Providers** (without Referral)

Dialysis treatment	N/A	80% of Allowable Charge*	Not covered
Home Health Care	N/A	80% of Allowable Charge*	Not covered
Hospice	N/A	80% of Allowable Charge*	Not covered
Private Duty Nursing Services	N/A	80% of Allowable Charge*	Not covered
Speech Therapy for the limited treatment of autism and autism spectrum disorder(s) are subject to the following limitations: –Covered Persons under age six shall be entitled to the Benefits specified under Rehabilitative/ Habilitative Outpatient Therapy Services set forth in this Plan for Physical Therapy, Occupational Therapy and Speech Therapy. – Covered Persons age six and older are subject to the limitations specified under Rehabilitative/Habilitative Outpatient Therapy Services set forth in this Plan.	N/A	80% of Allowable Charge*	Not covered
Voluntary sterilization (male)	N/A	80% of Allowable Charge*	Not covered

Additional Covered Services	**In Network Provider** (Cost to Covered Person)	**Out-of-Network Provider** (Cost to Covered Person)
Mammography Screening not subject to Deductible, Copayment or Coinsurance	No Charge	Not covered
Prostate Cancer Screening not subject to Deductible, Copayment or Coinsurance	No Charge	Not covered
Colorectal Cancer Screening	No Charge	Not covered

Bone Density Testing/Screening	No Charge	Not covered
Child immunizations – Birth through age 18; not subject to Deductible, Copayment, or coinsurance	No Charge	Not covered
Female Sterilization	No Charge	Not covered
Wigs/Scalp Prostheses - Limited to one per benefit period	No Charge	No Charge

ADDITIONAL COVERED SERVICES

Urgent Bone Marrow Transplant Benefits Within National Institutes of Health Clinical Trials Only - Bone Marrow Transplants that are otherwise excluded by this Plan as Experimental, Investigational and/or unproven (see Definitions and Exclusions and Limitations sections) are eligible for benefits if the Bone Marrow Transplant meets the following criteria:

- It is therapeutic (not diagnostic or supportive) treatment used to directly improve health outcomes for a condition that is life threatening and that has a poor prognosis with the most effective conventional treatment.
- For purposes of this provision, a condition is considered life threatening if it has a substantial probability of causing premature death and all other conventional treatments have failed, or are not medically appropriate;
- The Bone Marrow Transplant is available to the Covered Person seeking it and will be provided within a Clinical Trial conducted or approved by the National Institutes of Health;
- The Bone Marrow Transplant is not available free or at a reduced rate; and
- The Bone Marrow Transplant is not excluded by another provision of this Plan.

COVERED SERVICES RELATED TO CLINICAL TRIALS

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

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

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

Benefits may not be available under this section for services that are paid for by the research institution conducting the clinical trial. For purposes of this provision, "Routine Patient Costs" generally include all items and services consistent with the coverage provided under this Certificate for an individual with a similar condition who is not enrolled in a clinical trial. However, costs associated with the following are not Covered Services:

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

COVERED SERVICES RELATED TO 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 24 hours of Inpatient care following a lymph node dissection for the treatment of breast cancer, and
- Not less than 48 hours of Inpatient care following a mastectomy.

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.

COVERED SERVICES RELATED TO GENDER DYSPHORIA

Procedures and surgeries and related services will be considered medically necessary when meeting the American Psychiatric Association criteria for gender dysphoria as determined by two independent psychiatric evaluations. Otherwise, gender reassignment surgery and related services will be considered NOT medically necessary.

BENEFIT FOR EXPOSURE TO BLOODBORNE PATHOGENS

Eligibility and Coverage Requirement

All University of Oklahoma Health Sciences Center (HSC) students (in Oklahoma City or Tulsa) enrolled in this Plan are automatically covered for this benefit. All HSC and Norman-based students participating in clinical learning environments are required to enroll in coverage for potential exposures to needle sticks, other sharps, and spatter of blood or other body fluids that may result in exposure to pathogens. Students who are not covered under this Plan will be required to enroll in the Stand Alone Needlestick coverage and pay the cost of the annual Stand Alone Needlestick coverage. Students may waive this Stand Alone Needlestick coverage requirement by providing evidence of coverage that provides the same or greater benefits for exposure to bloodborne pathogens.

Enrollment and Coverage Periods

Students enrolled in the Enrollment for the Stand Alone Needlestick coverage is annual only, July 1 through June 30 each year. All Coverage Periods falling within the annual enrollment period are covered as long as the Covered Individual is enrolled in and attending a covered class, lab, or practicum.

Benefits

- Plan Maximum $2,000 per policy year
- Plan Pays 100% at OU Physicians Student Health & Wellness Clinic (OKC), Student Health Clinic* (Tulsa) and In-Network Provider facilities
- Covered Expenses
    - Outpatient Doctor Visits
    - Outpatient Laboratory Tests
    - Emergency Room Visits
    - Medications necessary to treat exposure to a needle stick/body fluid splatter or blood-borne pathogen

Claims Procedures

A Bloodborne Pathogens and Bodily Exposure Incident Form must be completed for each exposure. All related claims must be submitted using the primary diagnosis code Z77.21.

Pediatric Vision Benefits
For Covered Persons Under Age 19

Pediatric Vision Care

This *Pediatric Vision Care Section* provides information about coverage for the routine vision care services outlined below, which are specifically excluded under a Covered Person's medical/surgical benefits of this Plan. **(Services that are covered under a Covered Person's medical/surgical benefits of this Plan are not covered under this *Pediatric Vision Care Section*.) All provisions in this Plan apply to this *Pediatric Vision Care Section* unless specifically indicated otherwise below.**

This vision care benefit allows Covered Persons to select the Provider of their choice, in or out of the Network. BCBSOK has designed benefit plans to deliver quality care, matched with comprehensive benefits, at the most affordable cost, through Network services. Covered Persons will have a higher benefit level if they choose to receive Pediatric Vision Care services from a Network Provider.

Definitions

Benefit Period – For purposes of this *Pediatric Vision Care Section*, a period of time that begins on the later of: 1) the Covered Person's Effective Date of coverage under this *Pediatric Vision Care Section*, or 2) the last date a vision examination was performed on the Covered Person or that Vision Materials were provided to the Covered Person, whichever is applicable. (A benefit period does not coincide with a calendar year and may differ for each Covered Person of a group or family.)

Provider – For purposes of this *Pediatric Vision Care Section*, a licensed ophthalmologist or optometrist operating within the scope of his or her license, or a dispensing optician.

Vision Materials – Corrective lenses and/or frames or contact lenses.

Eligibility

Covered Persons who are covered under this Plan's medical/surgical benefits, up to age 19, are eligible for coverage under this *Pediatric Vision Care Section*. NOTE: Once coverage is lost under the medical/surgical benefits of this Plan, all benefits cease under this *Pediatric Vision Care Section*. Extension of benefits due to disability, state or federal continuation coverage, and conversion option privileges are **not** available under this *Pediatric Vision Care Section*.

Limitations and Exclusions

In addition to the general limitations and exclusions listed in this Plan, this *Pediatric Vision Care Section* does not cover services or materials connected with or charges arising from:

- any vision service, treatment or materials not specifically listed as a covered service;
- services and materials not meeting accepted standards of optometric practice;
- services and materials resulting from a Covered Person's failure to comply with professionally prescribed treatment;
- telephone consultations;
- any services that are strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
- services or materials provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
- office injection control charges;
- charges for copies of Covered Person's records, charts, or any costs associated with forwarding/mailing copies of Covered Person's records or charts;
- state or territorial taxes on vision services performed;
- medical treatment of eye disease or injury;
- visual therapy;
- special lens designs or coatings other than those described in this section;
- replacement of lost/stolen eyewear;

- non-prescription (Plano) lenses;
- two pairs of eyeglasses in lieu of bifocals;
- services not performed by licensed personnel;
- prosthetic devices and services;
- insurance of contact lenses;
- professional services a Covered Person receives from immediate relatives or household members, such as a spouse, parent, child, brother or sister, by blood, marriage or adoption;
- services covered under the medical/surgical benefits of this Plan;
- replacement of lost, stolen, damaged, or broken materials, unless otherwise covered through warranty;
- services of unlicensed personnel.
- Compound medications. For purposes of this exclusion. "compound medications" are customized medications made my mixing, assembling, packaging labeling drugs that are not commercially available in a specific dosage form strength, or formulation;
- non-FDA approved drugs;

pharmaceutical aids such as excipients found in the USP-NF (United States Pharmacopeia-National Formulary) including, but not limited to, preservatives, solvents, ointment bases, and flavoring, coloring, diluting, emulsifying, and suspending agents.

How the Vision Care Plan Works

Under the pediatric vision care plan, a Covered Person may visit any covered Provider and receive benefits for a vision examination. In order to maximize benefits for most covered Vision Materials, however, a Covered Person must purchase them from a Network Provider.

Before a Covered Person goes to a Network vision care plan Provider for an eye examination, eyeglasses, or contact lenses, he/she should call ahead for an appointment. When a Covered Person arrives, he/she should show the receptionist their Identification Card.

For a list of Vision Care Network Providers, please contact a Customer Service Representative at 844-684-2256, or visit www.eyemed.com , for the online EyeMed Provider locator to determine which participating Providers have agreed to the discounted rate (please choose the Select network for the search).

If a Covered Person obtain glasses or contacts from an Out-of-Network Provider, he/she must pay the Provider in full and submit a claim for reimbursement (Covered Persons should see the Claims Processing section of this Plan for more information).

A Covered Person may receive his/her eye examination and eyeglasses/contacts on different dates or through different Provider locations, if desired. However, complete eyeglasses must be obtained at one time, from one Provider. Continuity of care will best be maintained when all available services are obtained at one time from one Network Provider and there may be additional professional charges if a Covered Person seeks contact lenses from a Provider other than the one who performed his/her eye examination.

Fees charged for services other than a covered vision examination or covered Vision Materials and amounts in excess of those payable under this *Pediatric Vision Care Section*, must be paid in full by the Covered Person to the Provider, whether or not the Provider participates in the vision care plan network.

Benefits under this *Pediatric Vision Care Section* may not be combined with any discount, promotional offering, or other group benefit plans. Allowances are one-time use benefits; no remaining balances are carried over to be used later.

Schedule of Pediatric Vision Coverage

Vision Care Services	**In-Network Covered Person Cost or Discount** (When a fixed-dollar copayment is due from the Covered Person, the remainder is payable by the Plan up to the covered charge*)	**Out-of-Network Allowance** (maximum amount payable by the Plan, not to exceed the retail cost)**
Exam (with dilation as necessary):	No Copayment	Up to $30
Frames:		
"Collection" Frame Non-Collection Frames Note: "Collection" frames with retail values up to $225 are available at no cost at most participating independent Providers. Retail chain Providers typically do not display the "Collection," but are required to maintain a comparable selection of frames that are covered in full.	No Copayment Covered Individual receives 20% off balance of retail cost over $150 allowance	Up to $75 Up to $75
Frequency: Examination, Lenses, or Contact Lenses Frame	Once every 12-month benefit period Once every 12-month benefit period	

Vision Care Services (cont'd)	In-Network Covered Person Cost or Discount	Out-of-Network Allowance
Standard Plastic, Glass, or Poly Spectacle Lenses		
Single Vision	No Copayment	Up to $25
Lined Bifocal	No Copayment	Up to $40
Lined Trifocal	No Copayment	Up to $55
Lenticular	No Copayment	Up to $55
Note: Lenses include fashion and gradient tinting, oversized and glass grey #3 prescription sunglass lenses. All lenses include scratch resistant coating with no additional Copayment. There may be an additional charge at Walmart and Sam's Club.		

Lens Options (add to lens prices above): Ultraviolet Protective Coating Polycarbonate Lenses Blended Segment Lenses Intermediate vision Lenses Standard Progressives	 No Copayment No Copayment $20 Copayment $30 Copayment No Copayment	 $12 $32 Not Covered Not Covered $55
Premium Progressive (Varilux®, etc.) Tier 1 Tier 2 Tier 3 Tier 4	 $20 Copayment $30 Copayment $45 Copayment $0 Copayment, 80% of charge less than $120	 Not Covered Not Covered Not Covered Not Covered
Plastic Photosensitive Lenses (Transitions®) Polarized Lenses Standard Anti-Reflective (AR) Coating Premium AR Coating Ultra AR Coating High Index Lenses Progressive Lens Options – Covered Persons may receive a discount on **additional** progressive lens options: Select Progressive Lenses Ultra Progressive Lenses	No Copayment 20% off Retail $45 Copayment $57 Copayment $68 Copayment 20% off Retail $85 Copayment Varies by Lens Tier	$57 Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered

Vision Care Services (cont'd)	In-Network Covered Person Cost or Discount	Out-of-Network Allowance
Contact Lenses: covered once every calendar year – in lieu of eyeglasses Elective	 Covered Person receives 15% off balance of retail cost over $150 allowance ($150 allowance may be applied toward the cost of evaluation, materials, fitting and follow-up care) Covered at 100%	 Up to $150 Up to $210

Medically Necessary contact lenses – preauthorization is required Note: In some instances, participating Providers may charge separately for the evaluation, fitting, or follow-up care relating to contact lenses. Should this occur and the value of the contact lenses received is less than the allowance, a Covered Person may submit a claim for the remaining balance (the combined reimbursement will not exceed the total allowance).		
Note: Additional benefits over allowance are available from participating Providers except Walmart and Sam's Club.		
Routine eye exams do not include professional services for contact lens evaluations. Any applicable fees are the responsibility of the patient.		
Value-added features: **Laser vision correction:** A Covered Person will receive a discount for traditional LASIK and custom LASIK from participating Physicians and affiliated laser centers. Covered Persons must obtain preauthorization for this service. *Prices/discounts may vary by state and are subject to change without notice.* **Mail-order contact lens replacement:** Lens 1-2-3® Program (visit the Lens 1-2-3 website: www.lens123.com).		

Vision Care Services (cont'd)	In-Network Covered Person Cost or Discount	Out-of-Network Allowance
Medically Necessary contact lenses: Contact lenses may be determined to be medically necessary and appropriate in the treatment of patients affected by certain conditions. In general, contact lenses may be medically necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Contact lenses may be determined to be medically necessary in the treatment of the following conditions: Keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, irregular astigmatism. Medically necessary contact lenses are dispensed in lieu of other eyewear. Participating Providers will obtain the necessary preauthorization for these services.		
Low Vision: Low vision is a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in low vision care can evaluate and prescribe optical devices and provide training and instruction to maximize the remaining usable vision for Our Covered Persons with low vision. After preauthorization, covered low vision services (both In- and Out-of-Network) will include one comprehensive low vision evaluation every 5 years, with a maximum charge of $300; maximum		

low vision aid allowance of $600 with a lifetime maximum of $1,200 for items such as high-power spectacles, magnifiers and telescopes; and follow-up care – four visits in any five-year period, with a maximum charge of $100 each visit. Participating Providers will obtain the necessary preauthorization for these services.
Warranty: Warranty limitations may apply to Provider or retailer supplied frames and/or eyeglass lenses. Covered Persons should ask their Provider for details of the warranty that is available to them.

*The "covered charge" is the rate negotiated with Network Providers for a particular covered service.

**The Plan pays the lesser of the maximum allowance noted or the retail cost. Retail prices vary by location.

Pediatric Dental Benefits
For Covered Persons Under Age 19

Your dental benefits are highlighted below. To fully understand all the terms, conditions, limitations and exclusions which apply to your Benefits, please read your entire Plan.

The Deductibles, Coinsurance, Benefit Period Maximums and/or Out-of-Pocket Limits below are subject to change as permitted by applicable law.

Schedule of Pediatric Dental Benefits

COVERED SERVICES	BENEFIT PAYABLE Services Obtained From:	
	Participating Dentist	Out-of-Network Dentist*
Diagnostic Evaluations (Deductible waived)	80% of Allowable Charge	60% of Allowable Charge
Preventive Services (Deductible waived)	80% of Allowable Charge	60% of Allowable Charge
Diagnostic Radiographs (Deductible waived)	80% of Allowable Charge	60% of Allowable Charge
Miscellaneous Preventive Services	80% of Allowable Charge	60% of Allowable Charge
Basic Restorative Services	50% of Allowable Charge	30% of Allowable Charge
Non-Surgical Extractions	50% of Allowable Charge	30% of Allowable Charge
Non-Surgical Periodontal Services	50% of Allowable Charge	30% of Allowable Charge

Adjunctive General Services	50% of Allowable Charge	30% of Allowable Charge
Endodontic Services	50% of Allowable Charge	30% of Allowable Charge
Oral Surgery Services	50% of Allowable Charge	30% of Allowable Charge
Surgical Periodontal Services	50% of Allowable Charge	30% of Allowable Charge
Major Restorative Services	50% of Allowable Charge	30% of Allowable Charge
Prosthodontic Services	50% of Allowable Charge	30% of Allowable Charge
Miscellaneous Restorative and Prosthodontic Services	50% of Allowable Charge	30% of Allowable Charge

COVERED SERVICES	BENEFIT PAYABLE Services Obtained From:	
	Participating Dentist	Out-of-Network Dentist*
Medically Necessary Orthodontia (Deductible waived)		
Pediatric Orthodontic Services: Coverage limited to children under age 19 with an orthodontic condition meeting Medical Necessity criteria established by the Plan (e.g., severe, dysfunctional malocclusion)	50% of Allowable Charge	30% of Allowable Charge
Optional Orthodontic Services: Coverage for orthodontic conditions not meeting Medical Necessity criteria established by the Plan	Not Covered	
Deductible		
Individual	$75	
Family Deductible	$225	
Benefit Period Maximum – Excluding any Orthodontic Services (In/Out-of-Network accumulate together)	Unlimited	
Out-of-Pocket Maximum per Benefit Period		
1 Child	$350	No Limit
2+ Children	$700	No Limit
*For Out-of-Network Provider services, the Allowable Charge is the Provider's usual charge, not to exceed the amount that the Plan would reimburse a Participating Provider for the same services. The Covered Person may be responsible for the full amount by which the actual charges of an Out-of-Network Provider exceed the Allowable Charge.		

Covered Dental Services

The Benefits of this section are subject to all the terms and conditions of your Plan. Benefits are available only for services and supplies that are determined by the Plan to be "Medically Necessary", unless otherwise specified. All Covered Services listed in this section are subject to the ***Exclusions and Limitations*** section of this Plan, which lists services, supplies, situations or related expenses that are not covered.

It is important for you to refer to your *Schedule of Benefits* to find out what a Subscriber's Deductible, Coinsurance and Benefit Period Maximum will be for a Covered Service. If you do not have a *Schedule of Benefits*, please call a Customer Service Representative at 1-855-267-0214.

A Covered Person's Dental Benefits include coverage for the following Covered Services as long as these services are rendered to a Subscriber by a Dentist or a Physician. When the term "Dentist" is used in this Plan, it will mean Dentist or Physician.

DIAGNOSTIC EVALUATIONS

Diagnostic evaluations aid the Dentist in determining the nature or cause of a dental disease and include:

• Periodic oral evaluations for established patients.

• Problem-focused oral evaluations, whether limited, detailed or extensive.

• Comprehensive oral evaluations for new or established patients.

• Comprehensive periodontal evaluations for new or established patients.

• Oral evaluations of children, including counseling with primary caregiver.

Benefits for periodic and comprehensive oral evaluations are limited to a combined maximum of two every 12 months. In addition, Benefits for problem-focused oral evaluations and comprehensive periodontal evaluations are limited to a combined maximum of two every 12 months.

Benefits will not be provided for comprehensive periodontal evaluations or problem-focused evaluations if Covered Services are rendered on the same date as any other oral evaluation and by the same Dentist.

Benefits will not be provided for tests and oral pathology procedures, or for re-evaluations.

PREVENTIVE SERVICES

Preventive services are performed to prevent dental disease. Covered Services include:

• Prophylaxis – Professional cleaning, scaling and polishing of the teeth. Benefits are limited to two cleanings every 12 months. Additional Benefits will not be provided for prophylaxis based on degree of difficulty.

• Topical Fluoride Application – Benefits for Fluoride Application are limited to two applications every 12 months.

Special Provisions Regarding Preventive Services

Cleanings include associated scaling and polishing procedures.

Combination of prophylaxes and periodontal maintenance treatments (see "*Non-Surgical Periodontal Services*") are limited to two every 12 months.

DIAGNOSTIC RADIOGRAPHS

Diagnostic radiographs are x-rays taken to diagnose a dental disease, including their interpretations, and include:

• Full-mouth (intraoral complete series) and panoramic films – Benefits are limited to a combined maximum of one every 36 months.

• Bitewing films – Benefits are limited to four horizontal films or eight vertical films two every 12 months. However, Benefits are not available for bitewing films taken on the same date as full mouth films.

• Periapical films, as Medically Necessary for diagnosis

Benefits will not be provided for any radiographs taken in conjunction with Temporomandibular Joint (TMJ) Dysfunction.

MISCELLANEOUS PREVENTIVE SERVICES

Miscellaneous preventive services are other services performed to prevent dental disease and include:

• Sealants – Benefits for sealants are limited to one per permanent molar per lifetime

• Space Maintainers
• Smoking and tobacco use cessation counseling.

Benefits are not available for nutritional or oral hygiene counseling, except as provided under the pediatric dental benefits for Covered Persons to the age of 19.

BASIC RESTORATIVE SERVICES

Basic restorative services are restorations necessary to repair basic dental decay, including tooth preparation, all adhesives, bases, liners, and polishing. Covered Services include:

• Amalgam restorations
• Resin-based composite restorations

NON-SURGICAL EXTRACTIONS

Non-surgical extractions are non-surgical removal of tooth and tooth structures and include:

• Removal of retained coronal remnants – deciduous tooth.

• Removal of erupted tooth or exposed root.

NON-SURGICAL PERIODONTAL SERVICES

Non-surgical periodontal service is the non-surgical treatment of a dental disease in the supporting and surrounding tissues of the teeth (gums) and includes:

• Periodontal scaling and root planing – Benefits are limited to one per quadrant every 24 months.

• Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis limited to once every 12 months.

• Periodontal maintenance procedures – Benefits are limited to two every 12 months in combination with routine oral prophylaxis and must be performed following active periodontal treatment.

Benefits will not be provided for chemical treatments, localized delivery of chemotherapeutic agents without history of active periodontal therapy, or when performed on the same date (or in close proximity) as active periodontal therapy.

ADJUNCTIVE GENERAL SERVICES

Adjunctive General Services include:

• Palliative treatment (emergency) of dental pain, and when not performed in conjunction with a definitive treatment.

• Deep sedation/general anesthesia and intravenous/non-intravenous conscious sedation – By report only and when determined to be Medically Necessary for documented Covered Persons with a disability or for a justifiable medical or dental condition. A person's apprehension does not constitute Medical Necessity.

Nitrous oxide analgesia is provided for Subscribers under age 19.

ENDODONTIC SERVICES

Endodontics is the treatment of dental disease of the tooth pulp and includes:

• Therapeutic pulpotomy and pulpal debridement, when performed as a final endodontic procedure.

• Root canal therapy, including treatment plan, clinical procedures, working and post-operative radiographs and follow-up care.

• Apexification/recalcification procedures and apicoectomy/periradicular services including surgery, retrograde filling, root amputation and hemisection.

Pulpal debridement is considered part of endodontic therapy when performed by the same Provider and not associated with a definitive emergency visit.

Benefits will not be provided for the following *"Endodontic Services"*:

• Endodontic retreatments provided within 12 months of the initial endodontic therapy by the same Dentist.

• Pulp vitality tests, endodontic endosseous implants, intentional reimplantations, canal preparation, fitting of preformed dowel and post or post removal.

• Endodontic therapy if a Subscriber discontinues endodontic treatment.

ORAL SURGERY SERVICES

Oral surgery means the procedures for surgical extractions and other dental surgery under local anesthetics and includes:

• Surgical tooth extractions.

• Alveoloplasty and vestibuloplasty.

• Excision of benign odontogenic tumor/cysts.

• Excision of bone tissue.

• Incision and drainage of an intraoral abscess.

• Other Medically Necessary surgical and repair procedures not specifically excluded in this Plan.

Intraoral soft tissue incision and drainage is only covered when it is provided as the definitive treatment of an abscess. Routine follow-up care is considered part of the procedure.

Benefits will not be provided for the following Oral Surgery procedures:

• Surgical services related to a congenital malformation.

• Prophylactic removal of third molars or impacted teeth (asymptomatic, nonpathological), or for complete bony impactions covered by another benefit plan.

• Excision of tumors or cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

• Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses); treatment of fractures of facial bones; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; reduction of dislocation, or excision of the temporomandibular joints.

SURGICAL PERIODONTAL SERVICES

Surgical periodontal service is the surgical treatment of a dental disease in the supporting and surrounding tissues of the teeth (gums) and includes:

• Gingivectomy or gingivoplasty and gingival flap procedures (including root planing) – Benefits are limited to one per quadrant every 24 months.

• Clinical crown lengthening.

• Osseous surgery, including flap entry and closure – Benefits are limited to one per quadrant every 24 months. In addition, osseous surgery performed in a limited area and in conjunction with crown lengthening on the same date of service, by the same Dentist, and in the same area of the mouth, will be processed as crown lengthening in the absence of periodontal disease.

• Osseous grafts – Benefits are limited to one per site every 24 months.

• Soft tissue grafts/allografts (including donor site) – Benefits are limited to one per site every 24 months.

• Distal or proximal wedge procedure.

• Anatomical crown exposures – Benefits are limited to one per quadrant every 24 months.

Surgical periodontal services performed in conjunction with the placement of crowns, inlays, onlays, crown buildups, posts and cores or basic restorations are considered part of the restoration.

Benefits will not be provided for guided tissue regeneration, or for biologic materials to aid in tissue regeneration.

MAJOR RESTORATIVE SERVICES

Restorative services restore tooth structures lost as a result of dental decay or fracture and include:

• Single crown restorations.

• Gold foil and inlay/onlay restorations.

• Labial veneer restorations.

Benefits will be provided for the replacement of a lost or defective crown. However, Benefits will not be provided for the restoration of occlusion or incisal edges due to bruxism or harmful habits.

Benefits for major restorations are limited to one per tooth every 60 months whether placement was provided under this Plan or under any prior dental coverage, even if the original crown was stainless steel. Crowns placed over implants will be covered.

PROSTHODONTIC SERVICES

Prosthodontics involves procedures Medically Necessary for providing artificial replacements for missing natural teeth and includes:

• Complete and removable partial dentures – Benefits will be provided for the initial installation of removable complete, immediate or partial dentures, including any adjustments, relines or rebases during the six-month period following installation. Benefits for replacements are limited to once in any 60-month

period, whether placement was provided under this Plan or under any prior dental coverage. Benefits will not be provided for replacement of complete or partial dentures due to theft, misplacement or loss.

• Denture reline/rebase procedures – Benefits will be limited to one procedure every 36 months.

• Fixed bridgework – Benefits will be provided for the initial installation of a bridgework, including inlays/onlays and crowns. Benefits will be limited to once every 60 months whether placement was under this Plan or under any prior dental coverage.

Prosthetics placed over implants will be covered.

Tissue conditioning is part of a denture or a reline/rebase, when performed on the same day as the delivery.

Benefits will not be provided for the following Prosthodontic Services:

• Splinting of teeth, including double retainers for removable partial dentures and fixed bridgework.

MISCELLANEOUS RESTORATIVE AND PROSTHODONTIC SERVICES

Other restorative and prosthodontic services include:

• Prefabricated crowns – Benefits for stainless steel and resin-based crowns are limited to one per tooth every 60 months. These crowns are not intended to be used as temporary crowns.

• Recementation of inlays/onlays, crowns, bridges, and post and core – Benefits will be limited to two recementations every 12 months. However, any recementation provided within six months of an initial placement by the same Dentist is considered part of the initial placement.

• Post and core, pin retention, and crown and bridge repair services.

• Pulp cap – direct and indirect.

• Adjustments – Benefits will be limited to three times per appliance every 12 months.

• Repairs of inlays, onlays, veneers, crowns, fixed or removable dentures, including replacement or addition of missing or broken teeth or clasp (unless additions are completed on the same date as replacement partials/dentures) are limited to a lifetime maximum of once per tooth or clasp.

The frequency limitation specified in the Plan for prefabricated crowns does not apply to Covered Persons under age 19.

ORTHODONTIC SERVICES

Orthodontic procedures and treatment include examination records, tooth guidance and repositioning (straightening) of the teeth for Covered Persons covered for orthodontics as shown on your ***Schedule of Pediatric Dental Benefits***. Covered Services include:

• Diagnostic orthodontic records and radiographs **Once every 60 months per Covered Individual.**

• Limited, interceptive, and comprehensive orthodontic treatment.

• Orthodontic retention, **once every 60 months per Covered Individual.**

Special Provisions Regarding Orthodontic Services:

• Orthodontic services are paid over the Course of Treatment, up to the maximum Benefit Period orthodontic Benefit. Benefits cease when the Subscriber is no longer covered, whether or not the entire Benefit has been paid out.

• Orthodontic treatment is started on the date the bands or appliances are inserted.

• Payment for diagnostic services performed in conjunction with orthodontics is applied to the orthodontic Benefit and subject to the Benefit Period Maximum for orthodontic services.

• If orthodontic treatment is terminated for any reason before completion, Benefits will cease on the date of termination.

• If the Subscriber's coverage is terminated prior to the completion of the orthodontic treatment plan, the Subscriber is responsible for the remaining balance of treatment costs.

• Recommendation of an orthodontic appliance by the same Provider who placed the appliance and/or who is responsible for the ongoing care of the Covered Person is not covered.

• Benefits are not available for replacement or repair of an orthodontic appliance.

• For services in progress on the Effective Date, Benefits will be reduced based on other benefits paid prior to this coverage beginning.

Pediatric Dental Exclusions and Limitations

These general ***Exclusions and Limitations*** apply to all services described in this Plan. Dental coverage is limited to services provided by a Dentist, a dental auxiliary, or other Provider licensed to perform services covered under this Plan.

IMPORTANT INFORMATION ABOUT YOUR DENTAL BENEFITS

- **Dental Procedures Which Are Not Medically Necessary**

  Please note that in order to provide Subscribers with dental care Benefits at a reasonable cost, this Plan provides Benefits only for those Covered Services for eligible dental treatment that are determined by the Plan to be Medically Necessary.

  No Benefits will be provided for procedures which are not Medically Necessary. Medically Necessary generally means that a specific procedure provided to a Subscriber is required for the treatment or management of a dental symptom or condition and that the procedure performed is the most efficient and economical procedure which can safely be provided to a Covered Person, as determined by the Plan.

The fact that a Physician or Dentist may prescribe, order, recommend or approve a procedure does not of itself make such a procedure or supply Medically Necessary.

- **Care by More Than One Dentist**

  If a Covered Person changes Dentists in the middle of a particular Course of Treatment, Benefits will be provided as if the Subscriber had stayed with the same Dentist until the Subscriber's treatment was completed. There will be no duplication of Benefits.

- **Alternate Benefits**

  In all cases in which there is more than one Course of Treatment possible, the Benefit will be based upon the most efficient Course of Treatment, as determined by the Plan.

  If a Covered Person and a Covered Person's Dentist or Physician decide on personalized restorations, or personalized complete or partial dentures and overdentures, or to employ specialized techniques for dental services rather than standard procedures, the Benefits provided will be limited to the Benefit for the standard procedures for dental services, as determined by the Plan.

- **Non-Compliance with Prescribed Care**

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

EXCLUSIONS — WHAT IS NOT COVERED

No Benefits will be provided under this Plan for:

• Services or supplies not specifically listed as a Covered Service, or when they are related to a noncovered service.

• Amounts which are in excess of the Allowable Charge, as determined by the Plan.

• Dental services for treatment of congenital or developmental malformation, or services performed for cosmetic purposes, including but not limited to bleaching teeth and grafts to improve aesthetics.

• Dental services or appliances for the diagnosis and/or treatment of temporomandibular joint dysfunction and related disorders, unless specifically mentioned in this Plan or if resulting from accidental injury. Dental services or appliances to increase vertical dimension, unless specifically mentioned in this Plan.

• Dental services which are performed due to an accidental injury. Injury caused by chewing or biting an object or substance placed in a Covered Person's mouth is not considered an accidental injury.

• Dental services which are performed due to injuries arising from Interscholastic Activities and Intercollegiate Sports.

• Services and supplies for any illness or injury suffered after the Covered Person's Effective Date as a result of war or any act of war, declared or undeclared, when serving in the military or any auxiliary unit thereto.

• Services or supplies that do not meet accepted standards of dental practice.

• Experimental, Investigational and/or Unproven services and supplies and all related services and supplies.

• Hospital and ancillary charges.

• Implants and any related services and supplies (other than crowns, bridges and dentures supported by implants) associated with the placement and care of implants.

• Services or supplies for which Covered Persons are not required to make payment or would have no legal obligation to pay if Covered Person did not have this or similar coverage.

• Services or supplies for which "discounts" or waiver of Deductible or Coinsurance amounts are offered.

• Services rendered by a Dentist related to a Covered Person by blood or marriage.

• Services or supplies received from someone other than a Dentist, except for those services received from a licensed dental hygienist under the supervision and guidance of a Dentist, where applicable.

• Services or supplies received for behavior management or consultation purposes.

• Any illness or injury occurring while covered under this plan if whole or partial compensation or benefits are, or might have been, available under the laws of any governmental unit; any policy of worker's compensation insurance; or according to any recognized legal remedy arising from any form of settlement. This applies whether or not Covered Persons claim the benefits or compensation or recover the losses from a third party.

– Covered Persons agree to:
  • pursue their 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 Covered Persons receive any money in settlement of their plan's liability, regardless of whether the settlement includes a provision for payment of their medical bills, they 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 the employer or insurance carrier.

• Any services or supplies to the extent payment has been made under Medicare or would have been made if a Covered Person 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).

• Charges for nutritional, tobacco or oral hygiene counseling for adults.

• Charges for local, state, or territorial taxes on dental services or procedures.

• Charges for the administration of infection control procedures as required by local, state or federal mandates.

• Charges for duplicate, temporary or provisional prosthetic device or other duplicate, temporary or provisional appliances.

• Charges for telephone consultations, email or other electronic consultations, missed appointments, completion of a claim form or forwarding requested records or x-rays.

• Charges for prescription or non-prescription mouthwashes, rinses, topical solutions, preparations or medicament carriers.

• Charges for personalized complete or partial dentures and overdentures, related services and supplies, or other specialized techniques.

• Charges for athletic mouth guards, isolation of tooth with rubber dam, metal copings, mobilization of erupted/malpositioned tooth, precision attachments for partials and/or dentures and stress breakers.

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• Any services, treatments or supplies included as Covered Services under other hospital, medical and/or surgical coverage.

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

• Charges for occlusion analysis or occlusal adjustments.

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

Definitions

Allowable Charge means the maximum amount determined by the claims administrator, BCBSOK, to be eligible for consideration of payment for a particular service, supply or procedure.

For Hospitals, Doctors and other providers contracting with BCBSOK or any other Blue Cross and Blue Shield Plan - The Allowable Charge is based on the terms of the Network Provider contract and the payment methodology in effect on the date of service. The payment methodology used may include diagnosis-related groups (DRG), fee schedule, package pricing, global pricing, per diems, case-rates, discounts, or other payment methodologies.

For Hospitals, Doctors and other providers not contracting with BCBSOK or any other Blue Cross and Blue Shield Plan (non-contracting Allowable Charge) - The Allowable Charge will be the lesser of: (i) the provider's billed charges, or; (ii) the non-contracting Allowable Charge.

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

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

In the event the non-contracting Allowable Charge does not equate to the Non-Contracting Provider's billed charges, the Covered Person will be responsible for the difference, along with any applicable Copayment, Coinsurance and Deductible amount. This difference may be considerable. To find out an estimate of the plan's non-contracting Allowable Charge for a particular service, Covered Persons may call customer service at the number on the back of the identification card.

For multiple surgeries - The Allowable Charge for all surgical procedures performed on the same patient on the same day will be the amount for the single procedure with the highest Allowable Charge plus a determined percentage of the Allowable Charge for each of the other covered procedures performed.

For Prescription Drugs as applied to Network Provider and Out-of-Network Provider Pharmacies - The Allowable Charge for pharmacies that are Network Providers will be based on the provisions of the contract between BCBSOK and the pharmacy in effect on the date of service. The Allowable Charge for pharmacies that are not Network Providers will be based on the Average Wholesale Price.

Copayment means a fixed dollar amount that the Covered Person must pay before benefits are payable under the Plan.

Covered Medic al Expense or Covered Expenses means expenses actually incurred by or on behalf of a Covered Person for treatment, services and supplies not excluded or limited by the Plan. Coverage under the Plan must remain continuously in force from the date the Accident or Sickness occurs until the date treatment, services or supplies are received for them to be a Covered Expense. A Covered Expense is deemed to be incurred on the date such treatment, service or supply, that gave rise to the expense or the charge, was rendered or obtained.

Deductible means the dollar amount of Covered Expenses that must be incurred as an out-of-pocket expense by each Covered Person on a Plan Year basis before benefits are payable under the Plan.

Doctor means a Doctor licensed to practice medicine. It also means any other practitioner of the healing arts who is licensed or certified by the state in which his or her services are rendered and acting within the scope of that license or certificate. It will not include a Covered Person or a member of the Covered Person's Immediate Family or household.

Injury means accidental bodily harm sustained by a Covered Person that results directly and independently from all other causes from a covered Accident. The Injury must be caused solely through external, violent, and accidental means. All injuries sustained by one person in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered a single Injury.

Covered Person means a person in a Class of Eligible Persons who enrolls for coverage and for whom the required Premium is paid making coverage in effect for that person.

Interscholastic Activities means playing, participating and/or traveling to or from an interscholastic, intercollegiate, club sports, professional, or semi-professional sport, contest or competition, including practice or conditioning for such activity.

Medically Necessary means those services or supplies covered under the plan which are:

• Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the condition, Sickness, disease, Injury, or bodily malfunction; and

• Provided in accordance with and are consistent with generally accepted standards of medical practice in the United States; and

• Not primarily for the convenience of the Participant, his Physician, Behavioral Health Practitioner, the Hospital, or the Other Provider; and

• The most economical supplies or levels of service that are appropriate for the safe and effective treatment of the Participant. When applied to hospitalization, this further means that the Participant requires acute care as a bed patient due to the nature of the services provided or the Participant's condition, and the Participant cannot receive safe or adequate care as an outpatient.

On behalf of the Plan, the medical staff of BCBSOK shall determine whether a service or supply is Medically Necessary under the plan and will consider the views of the state and national medical communities, the guidelines and practices of Medicare, Medicaid, or other government-financed programs, and peer reviewed literature. Although a Physician, Behavioral Health Practitioner or Professional Other Provider may have prescribed treatment, such treatment may not be Medically Necessary within this definition.

Network Provider means a Hospital, Doctor or other provider who has entered into an agreement with BCBSOK (and in some instances with other participating Blue Cross and/or Blue Shield Plans) to participate as a managed care provider.

Out-of-Network Provider means a Hospital, Doctor or other provider who has not entered into an agreement with BCBSOK (or other participating Blue Cross and/or Blue Shield Plan) as a managed care provider.

Sickness means an illness, disease or condition of the Covered Person that causes a loss for which a Covered Person incurs medical expenses while covered under the Plan. All related conditions and recurrent symptoms of the same or similar condition will be considered one Sickness

We, Our, Us means the Plan or any service provider with which the Plan or University contracts to operate the Plan or pay benefits.

Medical Exclusions and Limitations

Except as specified in this Plan, coverage is not provided for loss or charges incurred by or resulting from:

1. Problems, mental retardation, or for inpatient confinement for environmental change;

2. For which the provider of service customarily makes not direct charge to a Covered Person;

3. For treatment of an injury received while practicing, for, or participating in, any club, intercollegiate, professional sports or traveling to or from such an event as a member of an organized team representing the Services which are not prescribed by or performed by or upon the direction of a Doctor;

4. Services that are not Medically Necessary or in excess of the Allowable Charge;

5. Incurred during a Hospital confinement, regardless of Medical Necessity, when such services, supplies or charges are not approved in accordance with the Pre-Authorization process;

6. Which are in excess of the Allowable Charge;

7. Which are Experimental/Investigational in or unproven;

8. 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 government 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.
   - The Covered Person agrees to:
     - to pursue their rights under the workers' compensation laws;
     - to take no action prejudicing the rights and interests of the Plan; and

    - to cooperate and furnish information and assistance the Plan requires to help enforce it rights.
- If a Covered Person receives any money in settlement of their employer's liability, regardless of whether the settlement includes a provision for payment of their medical bills, the Covered Person agrees to:
    - 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 to repay the Plan any money recovered from their employer or insurance carrier.

9. 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);

10. For which you have no legal obligation to pay in the absence of this or like coverage;

11. 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;

12. For cosmetic treatment including prescription drugs, Surgery or complications resulting therefrom, including Surgery to improve or restore your appearance, unless: needed to repair conditions resulting from a covered accidental injury or malformation of a body member. Unless the surgery is medically necessary to improve the physiological functioning of the injured or malformed body member, or the surgery is to address gender dysphoria determined to be medically necessary under this plan. In no event will any care and services for breast reconstruction and implantation or removal of breast prostheses be a Covered Service unless such care and services are performed solely and directly as a result of Medically Necessary mastectomy;

13. Any expenses incurred in connection with sexual dysfunction, or sterilization reversal, vasectomy reversal;

14. Received from a member of your immediate family;

15. For any Inpatient 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;

16. Expenses for treatment rendered after your termination date;

17. For personal hygiene and convenience items regardless of whether or not recommended by a Doctor. Examples include but are not limited to: air conditioners, air purifiers or filters; humidifiers; or physical fitness equipment, including exercise bicycles or treadmills;

18. For telephone consultations, missed appointments, or completion of a claim form;

19. 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;

20. 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;

21. For routine or periodic physical examinations, except at Student Health Center or as specifically provided;

22. For screening examinations (except as specifically provided), including X-ray examinations without film;

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

24. 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.

25. 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; except as covered for pediatric vision benefits for Covered Persons up to age 19;

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

27. 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;

28. For treatment of sexual problems not caused by organic disease;

29. Weight management, weight reduction, or treatment for obesity including any condition resulting therefrom, including hernia of any kind;

30. For treatment of obesity, regardless of the history or diagnosis, including, but not limited to the following: weight reduction or dietary control programs; bariatric Surgery or other surgical procedures for weight reduction; 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;

31. Weight loss programs, except as related to treatment for diabetes;

32. For elective abortion, unless the life of the mother is endangered;

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

34. For treatment of an illness or injury received while skydiving, parachuting, hang gliding, glider flying, parasailing, sail planing, bungee jumping, or flight in any aircraft except as a passenger on a regularly scheduled commercial flight;

35. For treatment of temporomandibular joint dysfunction, included 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 involving the jaw joint, adjacent muscles or nerves, regardless of cause or diagnosis; that are not included as essential health benefits under this plan;

36. Which are not specifically named as Covered Services or covered as essential health benefits under this plan nor subject to any other specific Exclusions and Limitations in this plan;

37. Resulting from injury or sickness sustained while in the service of the Armed Forces of any country. Upon the Covered Person entering the Armed Forces, the plan will refund unearned pro-rata contribution;

38. Treatment of sleep disorders;

39. Gynecomastia, hirsutism;

40. Deviated nasal septum, including submucous resection and/or other surgical correction, unless due to an Injury occurring while continuous coverage is in effect;

41. Botox for any reason;

42. For injuries caused by bobsledding, or travel in or upon a snowmobile, an all-terrain vehicle (ATV) or any other 2- or 3-wheeled motor vehicle, unless the injuries were sustained traveling in or upon a 2- or 3-wheeled vehicle that is legally registered to be operated on public streets and highways, the operator was licensed to operate the vehicle, the injured covered person was wearing a helmet and all appropriate safety attire, and no traffic laws were being violated at the time such injuries were sustained.

43. For Speech Therapy and any related diagnostic testing, except as provided by a Hospital or rehabilitation facility as part of a covered Inpatient stay, or specifically as provided under the plan for the limited treatment of autism and autism spectrum disorder(s).

44. Treatment of temocclusion, 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; smoking cessation programs, not including counseling as specified under “Preventive Care Services”.

45. Prescription drug coverage is not provided for:
    - Refills in excess of the number specified or dispensed after one (1) year from the date of the Prescription;
    - Drugs labeled “Caution - limited by federal law to investigational use” or experimental drugs;

- Immunizing agents, biological sera, blood, or blood products administered on an outpatient basis; except as specifically provided in this Plan;
- Any devices, appliances, support garments, hypodermic needles except as used in the administration of insulin, or non-medical substances regardless of their intended use;
- Drugs used for cosmetic purposes, including, but not limited to, Retin-A for wrinkles, Rogaine for hair growth, anabolic steroids for body building, anorectics for weight control, etc.;
- Fertility agents or sexual enhancement drugs, medications or supplies for the treatment of impotence and/or sexual dysfunction, including but not limited to: Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, Viagra, Cialis, or Levitra;

- Lost or stolen prescriptions;
- Drugs prescribed and dispensed for the treatment of obesity or for use in any program of weight reduction, weight loss, or dietary control;
- Non-sedating antihistamine drugs and combination medications containing a nonsedating antihistamine and decongestant;
- Brand name proton pump inhibitors;
- Compound medications. For purposes of this exclusion. "compound medications" are substances made my 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;
- Drugs determined by the Plan to have inferior efficacy or significant safety issues;
- Drugs which are not approved by the U.S. Food and Drug Administration (FDA) for a particular use or purpose or when used for a purpose other than the purpose for which the FDA approval is given, except as required by law or regulation. This exclusion is not applicable to the coverage of the off-label use of Prescription Drugs for the treatment of cancer or the study of oncology in accordance with Oklahoma law; and
- Any portion of Covered Services or Covered Drugs paid for through Pharmacy coupons, drug cards or rebates.

Other Important Information

Academic Emergency Services*

To ensure immediate access to assistance if you experience a crisis while traveling over 100 miles from home, or outside your home country, Academic HealthPlans has included Academic Emergency Services (AES) benefits in your student health plan coverage. AES offers a wide range of services and benefits to provide everything you need to prepare for your international experience, as well as get the help or information you need in a crisis, no matter how large or small.

The following services and benefits are available to you 24 hours a day, 7 days a week:

Medical Assistance: Pre-travel information; physician referrals; medical monitoring to ensure adequate care; 24/7 Nurse Help Line; prescription assistance or medicine dispatch.

Emergency Medical Evacuation and Repatriation: Unlimited benefit for evacuation from inadequate facility to a higher level of care facility, repatriation home for continued care if medically necessary, or recovery and repatriation of deceased remains.

Accidental Death and Dismemberment: $25,000 benefit

Emergency Family Assistance: Benefits for visit of a family member or friend if hospitalized for 3 or more days, return of children if left unattended, bereavement reunion, emergency return home in the event a participant's family member suffers life threatening illness or death and return of participant's personal belongings in the event of evacuation or death.

Travel, Legal and Security Assistance: Pre-travel destination information or security advice; assistance locating lost luggage; passport replacement assistance; emergency travel arrangements; translation assistance; interpreter referral; legal consultation and referral; emergency message forwarding.

Preparing for your time away from home is easy;
simply visit the Academic Emergency Services portal:
aes.myahpcare.com

To obtain additional pre-travel information or advice, or in the event of a medical, travel or security crisis, call Academic Emergency Services immediately.
(855) 873-3555 call toll free from the US
+ 1 (410) 453-6354 call collect from anywhere
Email: assistance@ahpcare.com

This provides you with a brief outline of the services available to you. Terms, conditions, limitations and exclusions apply. All services must be arranged and paid for through the AES service provider. There is no claim process for reimbursement of self-paid expenses unless specifically described in the service plan.

*Academic Emergency Services (AES) is a global emergency services product. These services are provided by a separate and independent company from AES or Academic HealthPlans. AES provides medical, security and natural disaster evacuation services, repatriation of remains, emergency medical and travel assistance, travel information and other services for Academic HealthPlans.

BlueCard®

Like all Blue Cross and Blue Shield Licensees, we participate in a program called "BlueCard." Whenever the Covered Person accesses health care services outside Our service area, the Claims for those services may be processed through BlueCard and presented to Us for payment in conformity with network access rules of the BlueCard Policies then in effect ("Policies"). Under BlueCard, when Covered Persons incur Covered Expenses within the geographic area served by an onsite Blue Cross and/or Blue Shield Licensee ("Host Blue"), We will remain responsible to the Covered Person for fulfilling the Plan's contract obligations. The Host Blue will only be responsible, in accordance with applicable BlueCard Policies, if any, for providing such services as contracting with its participating providers and handling all interactions with its participating providers.

Summary of Benefits and Coverage

The Affordable Care Act requires all health insurers to provide consumers with a Summary of Benefits and Coverage (SBC). The SBC is a description of the benefits and health coverage offered by a particular health

plan. The SBC is intended to provide clear, consistent descriptions that may make it easier for people to understand their health insurance coverage.

The items in the SBC just represent an overview of coverage; they are not an exhaustive list of what is covered or excluded. The full terms of coverage are located in your Plan Document. To obtain an SBC for your Plan, please go to ***ou.myaphcare.com*** or ***ouhsc.myahpcare.com***.

BCBSOK Online Resources

BCBSOK members have online access to claims status, EOBs, ID cards, network providers, correspondence and coverage information by logging in to Blue Access for Members℠ (BAM). Visit BCBSOK.com and click on the "Log in" tab. Follow the simple, onscreen directions to establish an online account in minutes. Covered Persons under this Plan have full access to these services.

BAM has been enhanced to include BAM Mobile, a self-service tool that provides a quick and easy way to view any email notifications we may have sent. In Message Center, notifications are securely sent directly to the Covered Person's email address. If the Covered Person prefers to receive paper copies, he or she may opt-out of electronic delivery by going into My Email Preferences and making the change there.

Please go to ***ou.myaphcare.com*** or ***ouhsc.myahpcare.com*** for additional Premium and benefit information.

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.

CLAIM DETERMINATIONS

When the Plan receives a Properly Filed Claim, it has authority and discretion under this Plan to interpret and determine Benefits in accordance with the Plan provisions. We will receive and review claims for Benefits and will accurately process claims consistent with administrative practices and procedures established in writing.

You have the right to seek and obtain a full and fair review by the Plan of any determination of a claim, any determination of a request for Preauthorization, or any other determination of your Benefits made by the Plan.

IF A CLAIM IS DENIED OR NOT PAID IN FULL

On occasion, the claims administrator may deny all or part of your claim. There are a number of reasons why this may happen. We suggest that you first review this Plan to see whether you understand the reason for the determination. If you have additional information that you believe could change the decision, send it to BCBSOK and request a review of the decision as described in "Claim Appeal Procedures" below.

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

- The reasons for the determination;

- A reference to the Benefit provisions on which the determination is based, or the contractual, administrative or protocol for the determination;

- A description of additional information which may be necessary to perfect an appeal and an explanation of why such material is necessary;

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

- An explanation of Our internal review/appeals and external review processes (and how to initiate a review/appeal or external review);

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

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

- The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for Benefits;

- Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;

- An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances, if the denial was based on medical necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;

- In the case of a denial of an Urgent Care Clinical Claim, a description of the expedited review procedure applicable to such claims. An urgent care claim decision may be provided orally, so long as a written notice is furnished to the claimant within 3 days of oral notification; and

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

TIMING OF REQUIRED NOTICES AND EXTENSIONS

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

- **"Urgent Care Claim"** is any pre-service request for benefit(s) that requires Preauthorization, as described in this Plan, for Benefits for Medical Care or treatment with respect to which the application of regular time periods for making health claim decisions could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment.

- **"Pre-Service Claim"** is any non-urgent request for Benefits or a determination with respect to which the terms of the Benefit plan condition receipt of the Benefit on approval of the Benefit in advance of obtaining Medical Care.
- **"Post-Service Claim"** is any request for a Benefit that is not a "pre-service" claim, and whereby notification that a service has been rendered or furnished to you is submitted to the Plan in an acceptable form. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the claim charge, and any other information which We may request in connection with services rendered to you.

URGENT CARE CLAIMS

Type of Notice or Extension	Timing
If your claim is incomplete, we must notify you within:	**24 hours**
If you are notified that your claim is incomplete, you must then provide completed claim information to Us within	**48 hours** after receiving notice
If We deny your initial claim, We must notify you of the denial:	
if the initial claim is complete as soon as possible (taking into account medical exigencies), but no later than	**72 hours**
after receiving the completed claim (if the initial claim is incomplete), within:	**48 hours**

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

PRE-SERVICE CLAIMS

Type of Notice or Extension	Timing
If your claim is filed improperly, We must notify you within:	**5 days**
If your claim is incomplete, We must notify you within:	**15 days**

If you are notified that your claim is incomplete, you must then provide completed claim information to Us within:	**45 days** after receiving notice
If We deny your initial claim, We must notify you of the denial:	
if the initial claim is complete, within:	**15 days***
after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**

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

POST-SERVICE CLAIMS

Type of Notice or Extension	Timing
If your claim is incomplete, We must notify you within:	**30 days**
If you are notified that your claim is incomplete, you must then provide completed claim information to Us within:	**45 days** after receiving notice
If We deny your initial claim, We must notify you of the denial:	
if the initial claim is complete, within:	**30 days***
after receiving the completed claim (if the initial claim is incomplete), within:	**45 days**

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

CLAIM APPEAL PROCEDURES

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

An **"Adverse Benefit Determination"** means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Benefit, including any such denial, reduction, termination, or failure to provide or make payment for, a Benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which Benefits are otherwise provided because it is determined to be Experimental, Investigational or unproven or not Medically Necessary or appropriate. If an ongoing course of treatment had been approved by BCBSOK and reduces or terminates such treatment (other than by amendment or termination of this Plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination. A rescission of coverage is also an Adverse Benefit Determination. A rescission does not include a termination of coverage for reasons related to non-payment of Premium.

A **"Final Internal Adverse Benefit Determination"** means an Adverse Benefit Determination that has been upheld by the Plan at the completion of the internal review/appeal process.

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

  If your situation meets the definition of an Expedited Clinical Appeal, you may be entitled to an appeal on an expedited basis. An Expedited Clinical Appeal is an appeal of a clinically urgent nature related to health care services, including but not limited to, procedures or treatments ordered by a health care Provider, as well as continued hospitalization. Before authorization of Benefits for an ongoing course of treatment/continued hospitalization is terminated or reduced, We will provide you with notice at least 24 hours before the previous Benefits authorization ends and an opportunity to appeal. For the ongoing course of treatment, coverage will continue during the appeal process. Upon receipt of an expedited pre-service or concurrent clinical appeal, We will notify the party filing the appeal, as soon as possible, but no more than 24 hours after submission of the appeal, of all the information needed to review the appeal. Additional information must be submitted within 24 hours of request. The Plan shall render a determination on the appeal as soon as possible (taking into account medical exigencies) but no later than 72 hours after it receives the initial request, or within 48 hours after it receives the missing information (if the initial request is incomplete).

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

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

  An appeal of an Adverse Benefit Determination may be filed by you or a person authorized to act on your behalf. In some circumstances, a health care Provider may appeal on his/her own behalf. Your designation of a representative must be in writing, as it is necessary to protect against disclosure of information about you except to your authorized representative. To obtain an Authorized Representative Form, you or your representative may call Us at the number on the back of your Identification Card.
  If you believe We incorrectly denied all or part of your Benefits, you may have your claim reviewed. We will review its decision in accordance with the following procedure:

  - Within 180 days after you receive notice of a denial or partial denial, you may call or write to our Administrative Office. We will need to know the reasons why you do not agree with the denial or partial denial. Send your request to:

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

  - We will honor telephone requests for information. However, such inquiries will not constitute a request for review.

  - In support of your claim review, you have the option of presenting evidence and testimony to us.

  You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of an Adverse Benefit Determination or at any time during the claim review process.

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

- If you have any questions about the claims procedures or the review procedure, write to Our Administrative Office Customer Service Representative at the number shown on your Identification Card.

- **Timing of Appeal Determinations**

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

- **Notice of Appeal Determination**

We will notify the party filing the appeal, you, and, if a clinical appeal, any health care Provider who recommended the services involved in the appeal, by a written notice of the determination.

The written notice will include:

– A reason for the determination;

– A reference to the Benefit plan provisions on which the determination is based, or the contractual, administrative or protocol for the determination;

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

– An explanation of Our external review processes (and how to initiate an external review);

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

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

– The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for Benefits;

– Any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;

– An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;

– A description of the standard that was used in denying the claim and a discussion of the decision; and

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

EXTERNAL REVIEW RIGHTS

If you receive an Adverse Benefit Determination, you may have a right to have Our decision reviewed by independent health care professionals who have no association with *Us* ***if Our decision involved making a judgment as to the Medical Necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment.*** The request for a standard external review by an Independent Review Organization (IRO) must be submitted within four months after you receive notice of the internal appeal determination. For a standard external review, a decision will be made within **45 days** of receiving your request. If you have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed, you may request an **expedited external review** of our denial before your internal review rights have been exhausted. If our denial to provide or pay for a health care service or course of treatment is based on a determination that the service or treatment is Experimental, Investigational or Unproven, you also may be entitled to file a request for external review of our denial.

You or your authorized representative may file a request for a standard or expedited external review by completing the required forms and submitting them directly to the address noted below. We will also provide the forms to you upon request.

Oklahoma Insurance Department
3625 NW 56th Street
Oklahoma City, OK 73112-4511
Telephone: 1-800-522-0071 or 405-521-2828

There will be no charge to you for the IRO review. The IRO will notify you and/or your authorized representative of its decision, which will be binding on the Plan and on you, except to the extent you have additional remedies available.

For questions about your rights or for additional assistance, you may contact the Oklahoma consumer assistance program at:

Oklahoma Insurance Department
3625 NW 56th Street
Oklahoma City, OK 73112-4511

http://www.ok.gov/oid/Consumers/index.html
Telephone: 1-800-522-0071 or 405-521-2828

Claims Processing

In the event of Injury or Sickness, the student should:

1. Report to the Student Health Center for treatment, or, when not in school, to his/her Doctor or hospital. Covered Persons should go to a participating Doctor or hospital for treatment if possible.

IN AN EMERGENCY, REPORT DIRECTLY TO THE NEAREST EMERGENCY ROOM FOR TREATMENT.

2. Mail to the address below all prescription drug receipts (for providers outside of those contracting with Prime Therapeutics), medical and hospital bills, along with patient's name and Covered Student's name, address, Social Security Number, BCBSOK member ID Number and name of the University under which the student is covered.

3. File claims within 30 days of Injury or first treatment for a Sickness. Bills should be received by the Company within 90 days of service. Bills submitted after one year will not be considered for payment except in the absence of legal capacity.

The Plan is Administered by:
BCBSOK

Submit all claims or inquiries to:
Blue Cross and Blue Shield of Oklahoma
P.O. Box 3283
Tulsa, OK 74102-3283

BCBSOK Customer Service **(855) 267-0214**
Medical providers call **(800) 496-5774**
All Others: Call AHP **(888) 924-7758**

Plan is administered by:
Academic HealthPlans, Inc.
P.O. Box 1605
Colleyville, TX 76034-1605

Fax: **(855) 858-1964**

For more information
ou.myahpcare.com
ouhsc.myahpcare.com