AcademicBlue℠

East Central University Student Health Insurance Plan 2022-2023

Underwritten by:
Blue Cross and Blue Shield of Oklahoma

Please review to understand your coverage.

Dental Account Number: 295540

POLICYHOLDER:	East Central University
POLICY NUMBER:	295540 (“the Policy”)
POLICY EFFECTIVE DATE:	August 1, 2022
POLICY TERM:	August 1, 2022 through July 31, 2023
PREMIUM DUE DATE:	On or before August 1, 2022

This Policy describes the terms and conditions of coverage as issued to the Policyholder named above. The Policy is issued in the state of Oklahoma and is governed by its laws. The Policy becomes effective at 12:01 A.M. on the Policy Effective Date at the Policyholder’s address.

Blue Cross and Blue Shield of Oklahoma (“the Plan”), a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (the Insurer) and the Policyholder have agreed to all of the terms of the Policy as stated herein. In this Policy, “we”, “us”, “our” and the “Plan” mean Blue Cross and Blue Shield of Oklahoma. Any reference to “applicable law” will include applicable laws and rules, including but not limited to statutes, ordinances, and administrative decisions and regulations.

Policyholder has confirmed to Insurer that it is an Institution of higher education as defined in the Higher Education Act of 1965. This Policy does not make health insurance available other than in connection with enrollment as a Student (or a Dependent of a Student) in the Policyholder’s Institution. If Covered Persons have any questions once they have read this Policy, they can call us at the number shown on the back of their Identification Card. It is important to all of us that Covered Persons understand the protection this coverage gives them.

Signed for Blue Cross and Blue Shield of Oklahoma, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company by:

Stephania Grober
Plan President

Blue Cross and Blue Shield of Oklahoma
1400 S Boston
P.O. Box 3283
Tulsa, OK 74102-3283

BLANKET STUDENT ACCIDENT AND SICKNESS INSURANCE
PLEASE READ THIS POLICY CAREFULLY

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

Notice

Please note that the Plan has contracts with many health care Providers that provide for us to receive, and keep for our own account, payments, discounts and/or allowances with respect to the bill for services the Covered Person receives from those Providers.

The use of a metallic name, such as Platinum, Gold, Silver or Bronze, or other statements with respect to a health Benefit plan's actuarial value, is not an indicator of the actual amount of expenses that a particular person will be responsible to pay out of his/her own pocket. A person's out of pocket expenses will vary depending on many factors, such as the particular health care services, health care Providers and particular Benefit plan chosen. Please note that metallic names reflect only an approximation of the actuarial value of a particular Benefit plan.

WARNING, LIMITED BENEFITS WILL BE PAID WHEN OUT-OF-NETWORK PROVIDERS ARE USED

The Covered Person should be aware that when a Covered Person elects to utilize the services of an Out-of-Network Provider for treatment, services and supplies not excluded or limited by the Policy, in non–emergency situations, Benefit payments to such Out-of-Network Providers are not based upon the amount billed. The basis of the Covered Person's Benefit payment will be determined according to the Allowable Charges for Covered Services as determined by the Plan. THE COVERED PERSON CAN EXPECT TO PAY MORE THAN THE COINSURANCE OR COPAYMENT AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Except in the circumstances described below, Out-of-Network Providers may bill Students for any amount up to the billed charge after the Plan has paid its portion of the bill. Network Providers have agreed to accept discounted payments for services with no additional billing to the Student other than applicable Copayments, Coinsurance and Deductible amounts.

If services are obtained at a participating Hospital, at a participating surgery center or other participating treatment center, and services are provided by an Out-of-Network anesthesiologist (including a certified registered nurse anesthetist), pathologist, radiologist, neonatologist, or emergency room Physician, assistant surgeon (if the primary surgeon is a Network Provider) or other hospital-based Physician, the Covered Person will incur no greater out-of-pocket costs than would have been incurred if the services were provided by a Network Provider. For services provided by non-participating Provider, the nonparticipating Provider may not bill the Covered Person for the difference between payment by this Plan and the Provider charges plus In-Network Deductible, Coinsurance and/or Copayment.

The Covered Person may obtain further information about the participating status of Providers and information on Out-of-Pocket Maximums by calling the toll-free telephone number on the Covered Person's Identification Card. For questions concerning Out-of-Network Providers, please call the Plan's Customer Service at the number shown on the Identification Card. Should the Covered Person wish to know the Allowable Charge for a particular health care service or procedure or whether a particular Provider is a Network Provider or an Out-of-Network Provider, they may contact their Provider or the Plan. Should the Covered Person wish to know the estimated claim charge for a particular health care service or procedure, they should contact their Provider.

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Eligibility for Insurance

CLASSES OF ELIGIBLE PERSONS

Class I: International Students Only

All registered International students on non-immigrant visas, taking one (1) or more credit hours are required to participate in the East Central University Student Health Insurance Plan. Although Students are welome to submit an application for a waiver, in order to have such waiver approved, the plan submitted must be equivalent to the University Student Health Insurance Plan in all material respects.

Each person in one of the Class(es) of Eligible Persons shown above is eligible to be insured under this Policy. This includes anyone who is eligible on the Policy Effective Date and may become eligible after the Policy Effective Date while the Policy is in force. Students must meet the Institution's requirements for maintaining their status as an eligible Student. Students must maintain their eligibility in order to maintain or continue coverage under this Policy. Covered Students who lose eligibility status prior to the end of their enrolled coverage period will no longer be covered as of the first of the month following the loss of eligibility. Students enrolled for the Summer sessions will not experience a loss in coverage as long as they were covered immediately preceding the Summer sessions. We maintain the right to investigate Student status and attendance records to verify that eligibility requirements have been met. If we discover the eligibility requirements have not been met, our only obligation is to refund any unearned premium paid for that person.

Individuals who are eligible to receive Medicare Benefits are not eligible to enroll in this Plan, unless they fall within a federal exception.

No eligibility rules or variations in premium will be imposed based on a Student's health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or any other health status factor. A Student will not be discriminated against for coverage under this Policy on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or political affiliation expression. Coverage does not require documentation certifying a COVID-19 vaccination or require documentation of post-transmission recovery as a condition for obtaining coverage or receiving Benefits. Variations in the administration, processes or Benefits of this Policy that are based on clinically indicated, reasonable management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.

Schedule of Benefits

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

For questions concerning Out-of-Network Providers, Covered Persons should call a Customer Service Representative at the number shown on the Identification Card.

BENEFITS

Covered Persons' Benefits are highlighted below. However, to fully understand their Benefits, it is very important that Covered Persons read this entire Policy. This Policy is designed to provide Covered Persons with economic incentives for using designated Providers of health care services. Although Covered Persons can go to the Hospital or Physician of their choice, Benefits under the Policy will be greater when they use the services of a Network Provider.

Deductible:	**Network Provider**	**Out-of-Network Provider***
Per Covered Person per Benefit Period:	$250	
Out-of-Pocket Maximum:	**Network Provider**	**Out-of-Network Provider***
Per Covered Person per Benefit Period:	$6,600	
Covered Services	**Network Provider Covered Person Pays**	**Out-of-Network Provider* Covered Person Pays**
Preventive Care Services	No Charge	40% of Allowable Amount
Child Immunizations - Birth through age 18; not subject to Deductible, Copayment or Coinsurance	No Charge	No Charge
Routine Well-Child Care	No Charge	40% of Allowable Amount
Mammography Screening not subject to Deductible, Copayment or Coinsurance	No Charge	No Charge
Bone Density Testing	No Charge	40% of Allowable Amount
Prostate Cancer Screening not subject to Deductible	20% of Allowable Amount	40% of Allowable Amount
Colorectal Cancer Screening	No Charge	40% of Allowable Amount
Audiological Screening	20% of Allowable Amount	40% of Allowable Amount

Emergency Care Services **Accidents and Emergency Care (including Accidents and Emergency and Non-Emergency Care for Behavioral Health Services)**		
Facility charges (excluding Certain Diagnostic Procedures)	20% of Allowable Amount Subject to a $50 Copayment (Waived if admitted to the Hospital as an Inpatient immediately following emergency treatment.)	
Physician charges	20% of Allowable Amount	
Lab and x-ray charges	20% of Allowable Amount	
Hospital Services		
Inpatient Services	20% of Allowable Amount	40% of Allowable Amount
Surgical Services for a primary procedure – Remaining eligible procedure	20% of Allowable Amount	40% of Allowable Amount
Assistant Surgeon	20% of Allowable Amount	40% of Allowable Amount
Anesthetist Services	20% of Allowable Amount	40% of Allowable Amount
Physician's Visits	20% of Allowable Amount	40% of Allowable Amount
Psychiatric Care Services	20% of Allowable Amount	40% of Allowable Amount
Outpatient Services		
Surgical Services for a primary procedure - Remaining eligible procedures	20% of Allowable Amount	40% of Allowable Amount
Miscellaneous Surgical Services	20% of Allowable Amount	40% of Allowable Amount
Assistant Surgeon	20% of Allowable Amount	40% of Allowable Amount
Anesthetist	20% of Allowable Amount	40% of Allowable Amount
Non-Emergency Care		
Facility charges (excluding Certain Diagnostic Procedures)	20% of Allowable Amount Subject to a $50 Copayment (Waived if admitted to the Hospital as an Inpatient immediately following treatment.)	
Physician charges	20% of Allowable Amount	

Lab and x-ray charges	20% of Allowable Amount	
Urgent Care	20% of Allowable Amount	40% of Allowable Amount
Outpatient Physician's Visits	Subject to a $30 Copayment Deductible Waived	40% of Allowable Amount
Telehealth	20% of Allowable Amount	40% of Allowable Amount
Diagnostic X-ray and Laboratory Services	20% of Allowable Amount Deductible Waived	40% of Allowable Amount Deductible Waived
Tests and Procedures	20% of Allowable Amount	40% of Allowable Amount
Radiation and Chemotherapy	20% of Allowable Amount	40% of Allowable Amount
Outpatient Diagnostic Services	20% of Allowable Amount	40% of Allowable Amount
Outpatient Therapy Services	20% of Allowable Amount	40% of Allowable Amount
Maternity Services	20% of Allowable Amount	40% of Allowable Amount
Complications of Pregnancy	20% of Allowable Amount	40% of Allowable Amount
Mastectomy and Reconstructive Surgical Services	20% of Allowable Amount	40% of Allowable Amount
Human Organ, Tissue and Bone Marrow Transplant Services	20% of Allowable Amount	40% of Allowable Amount
Ambulatory Surgical Facility Services	20% of Allowable Amount	40% of Allowable Amount
Services Related to Treatment of Autism and Autism Spectrum Disorders Visit limits specified under "Outpatient Therapy Services" for Physical Therapy, Occupational Therapy and Speech Therapy are not applicable to treatment of Autism and Autism Spectrum Disorders.	20% of Allowable Amount	40% of Allowable Amount
Psychiatric Care Services	20% of Allowable Amount	40% of Allowable Amount
Severe Mental Illness	20% of Allowable Amount	40% of Allowable Amount
Ambulance Services including Air Ambulance	20% of Allowable Amount	
Private Duty Nursing Services Benefits will be limited to 85 visits per Benefit Period.	20% of Allowable Amount	40% of Allowable Amount

Rehabilitative/Habilitative Outpatient Therapy Services	20% of Allowable Amount	40% of Allowable Amount
Skilled Nursing Facility Services Benefits will be limited to 30 days per Benefit Period.	20% of Allowable Amount	40% of Allowable Amount
Home Health Care Services Benefits will be limited to 30 visits per Benefit Period.	20% of Allowable Amount	40% of Allowable Amount
Home Infusion Therapy	20% of Allowable Amount	30% of Allowable Amount
Hospice Services	20% of Allowable Amount	40% of Allowable Amount
Dental Treatment (Injury only to sound, natural teeth)	20% of Allowable Amount	40% of Allowable Amount
Diabetes Equipment, Supplies and Self-Management Services	20% of Allowable Amount	40% of Allowable Amount
Durable Medical Equipment	20% of Allowable Amount	40% of Allowable Amount
Prosthetic Appliances	20% of Allowable Amount	40% of Allowable Amount
Orthotic Devices	20% of Allowable Amount	40% of Allowable Amount
Wigs or Other Scalp Prostheses Maximum of one per Benefit Period	20% of Allowable Amount	40% of Allowable Amount

The Copayment and Coinsurance amounts shown above are subject to change or increase as permitted by applicable law.

* Covered Persons will be responsible for the difference between the Allowable Charge and the billed charges, when receiving Covered Services from an Out-of-Network Provider.

Schedule of Benefits for Outpatient Prescription Drugs

Note: The amount you may pay for a covered insulin drug shall not exceed $30 per 30-day supply or $90 per 90-day supply.

STUDENT HEALTH CENTER PHARMACY BENEFIT

Copayments/Coinsurance for Student Health Center Pharmacy Benefit*:	Student Health Center Pharmacy Covered Person Pays
Preferred Generic Drugs and Preferred Generic diabetic supplies, insulin, and insulin syringes	$15 Copayment
Non-preferred Generic Drugs and Non-preferred generic diabetic supplies, insulin, and insulin syringes	$15 Copayment
Preferred Brand Name Drugs and Preferred Brand Name diabetic supplies, insulin, and insulin syringes	$60 Copayment
Non-Preferred Brand Name Drugs and Non-Preferred Brand Name diabetic supplies, insulin, and insulin syringes for which there is a Generic Drug or supply available	$60 Copayment
Preferred Specialty Drugs	N/A
Non-Preferred Specialty Drugs	N/A

* One prescription means up to a 30 consecutive day supply of a drug (except for certain drugs). Students can purchase a 90-day supply for 3 times the schedule amount listed above.

OUTPATIENT PRESCRIPTION DRUG PROGRAM

Note: The amount you may pay for a covered insulin drug shall not exceed $30 per 30-day supply or $90 per 90-day supply.

Copayments/Coinsurance for Outpatient Prescription Drugs*:	Network Pharmacy Covered Person Pays	Out-of-Network Pharmacy Covered Person Pays**
Preferred Generic Drugs and preferred generic diabetic supplies and insulin and insulin syringes	$15 Copayment	40% of Allowable Amount after a $15 Copayment
Non-preferred Generic Drugs and non-preferred generic diabetic supplies and insulin and insulin syringes	$15 Copayment	40% of Allowable Amount after a $15 Copayment
Preferred Brand Name Drugs and preferred brand name diabetic supplies and insulin and insulin syringes	$60 Copayment	40% of Allowable Amount after a $60 Copayment
Non-Preferred Brand Name Drugs and non-formulary preferred brand name diabetic supplies and insulin and insulin syringes for which there is a Generic Drug or supply available	$60 Copayment	40% of Allowable Amount after a $60 Copayment
Preferred Specialty Drugs	N/A	N/A
Non-Preferred Specialty Drugs	N/A	N/A

* One prescription means up to a 30 consecutive day supply of a drug (except for certain drugs). Covered Persons can purchase a 90-day supply for 3 times the retail amount.

** Out-of-Network Pharmacies: When a Covered Person obtains Prescription Drugs, including diabetic supplies from an Out-of-Network Pharmacy (other than a Network Pharmacy), Benefits will be provided at 60% of the amount a Covered Person would have received had he/she obtained Prescription Drugs from a Network Pharmacy minus the Copayment amount or Coinsurance amount. Covered Persons will be responsible for the difference between the Allowable Charge and the billed charges, when receiving Prescription Drugs from an Out-of-Network Pharmacy.

Important Information

ACCIDENT AND SICKNESS MEDICAL EXPENSE BENEFITS

Unless otherwise specified, any Deductibles, Out-of-Pocket Maximums, Copayments, Coinsurance percentages and Benefit Maximums apply on a per Covered Person, per Benefit Period basis.

DEDUCTIBLE

After the Deductible and any Copayments have been satisfied, Benefits will be paid at the applicable Benefit rate up to any maximum that may apply.

OUT-OF-POCKET MAXIMUM

Once the Out-of-Pocket Maximum has been satisfied, with the exception of any applicable Out-of-Network Copayment, Covered Expenses will be payable at 100% for the remainder of the Benefit Period up to any maximum that may apply.

The Network Out-of-Pocket Maximum may be reached by:

- the Network Deductible;
- charges for Outpatient Prescription Drugs;
- the Hospital emergency room Copayment;
- the Copayment for Physician office visits;
- the Copayment for Specialist's office visits;
- the payments for which a Covered Person is responsible after Benefits have been provided (except for the cost difference between the Hospital's rate for a private room and a semi-private room or any expenses incurred for Covered Services rendered by an Out-of-Network Provider other than Emergency Care, and Inpatient treatment during the period of time when a Covered Person's condition is serious).

The following expenses cannot be applied to the Network Out-of-Pocket Maximum and will not be paid at 100% of the Allowable Charge when a Covered Person's Network Out-of-Pocket Maximum is reached:

- charges that exceed the Allowable Charge;
- the Coinsurance resulting from Covered Services rendered by an Out-of-Network Provider;
- penalty amounts for failing to follow Preauthorization requirements;
- services, supplies, or charges limited or excluded in this Policy;
- expenses not covered because a Benefit maximum has been reached;
- any Covered Expenses paid by the Primary Plan when this Policy is the Secondary Plan for purposes of Coordination of Benefits.

The Out-of-Network Out-of-Pocket Maximum may be reached by:

- the Out-of-Network Deductible;
- charges for Outpatient Prescription Drugs;
- the Hospital emergency room Copayment;
- the Urgent Care facility Copayment;

- the payments for Covered Services rendered by an Out-of-Network Provider for which a Covered Person is responsible after Benefits have been provided (except for the cost difference between the Hospital's rate for a private room and a semi-private room).

The following expenses cannot be applied to the Out-of-Network Out-of-Pocket Maximum and will not be paid at 100% of the Allowable Charge when a Covered Person's Out-of-Network Out-of-Pocket Maximum is reached:

- charges that exceed the Allowable Charge;
- the Coinsurance resulting from Covered Services a Covered Person may receive from a Network Provider;
- penalty amounts for failing to follow Preauthorization requirements;
- services, supplies, or charges limited or excluded in this Policy;
- expenses not covered because a Benefit maximum has been reached;
- any Covered Expenses paid by the Primary Plan when this Policy is the Secondary Plan for purposes of Coordination of Benefits.

Should the federal government adjust the Deductible(s) and/or Out-of-Pocket Maximum(s) applicable to this type of coverage, the Deductible and/or the Out-of-Pocket Maximums in this Policy will be adjusted accordingly.

ALLOWABLE CHARGE

To take full advantage of the negotiated pricing arrangements in effect between the Plan and our Network Providers, it is imperative that Covered Persons use Network Providers in Oklahoma and BlueCard Providers whenever they are out of state. Using a Network Provider offers Covered Persons the following advantages:

- Network and BlueCard Providers have agreed to hold the line on health care costs by providing special prices for our Covered Persons. These Providers will accept this negotiated price (called the "Allowable Charge") as payment for Covered Services. This means that, if a Network Provider bills the Covered Person more than the Allowable Charge for Covered Services, they are not responsible for the difference.
- The Plan will calculate a Covered Person's Benefits based on this "Allowable Charge". The Plan will deduct any charges for services which are not eligible under the Covered Person's coverage, then subtract any Deductibles, Copayments and/or Coinsurance amounts which may be applicable to their Covered Services. The Plan will then determine the Covered Person's Benefits under this Policy and direct any payment to their Network Provider.

Covered Persons receive the maximum Benefits allowed whenever they utilize the services of an Oklahoma Network Provider or a BlueCard Provider outside the state of Oklahoma.

The following method will be used for determining the Allowable Charge for Providers who do not have a participating Provider agreement with the Plan (Non-Contracting Providers):

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

For services for which a Medicare reimbursement rate is not available, the Allowable Charge for Non-Contracting Providers will represent an average contract rate for Network Providers adjusted by a

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

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

In the event the Non-Contracting Allowable Charge does not equate to the Non-Contracting Provider's billed charges, the 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 the Customer Service number shown on the back of their Identification Card.

- Notwithstanding anything in this Policy to the contrary, for Out-of-Network Emergency Care services rendered by Non-Contracting Providers, the Allowable Charge shall be equal to the greatest of the following three possible amounts—not to exceed billed charges:
    1. the median amount negotiated with network or contracting Providers for the Emergency Care services furnished;
    2. the amount for the Emergency Care services calculated using the same method the Plan generally uses to determine payments for Out-of-Network Provider services, but substituting the in-network or contracting cost-sharing provisions for the Out-of-Network or Non-Contracting Provider cost-sharing provisions; or
    3. the amount that would be paid under Medicare for the Emergency Care services.

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

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

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

- Charges for any services which are not covered under their Plan.
- Any Deductible, Copayment and/or Coinsurance amounts that are applicable to their coverage.
- The difference, if any, between their Provider's billed charges and the Allowable Charge determined by the Host Plan.

PREAUTHORIZATION REQUIREMENTS

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

Covered Persons are responsible for satisfying the requirements for *"Preauthorization"*. This means that a Covered Person must request Preauthorization or assure that their Physician, Provider of services, or

a family member complies with the **requirements** below. Failure to Preauthorize services may result in a reduction in Benefits as described below under *"Failure to Preauthorize"*.

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

Preauthorization Process for Inpatient Services

For an Inpatient facility stay, *a Covered Person must request Preauthorization from the Plan as soon as possible, but no later than one business day* ***before*** *their scheduled admission*. The Plan will consult with their Physician, Hospital, or other facility to determine if Inpatient level of care is required for their illness or Injury. The Plan may decide that the treatment the Covered Person needs could be provided just as effectively in a different setting (such as the Outpatient department of the Hospital, an Ambulatory Surgical Facility, or the Physician's office). If the Plan determines that the treatment does not require Inpatient care, the Covered Person and their Provider will be notified of that decision. **If a Covered Person proceeds with an Inpatient stay without the Plan's approval, or if the Covered Person does not ask the Plan for Preauthorization, their Benefits under this Policy will be reduced, as described below under *"Failure to Preauthorize"*, provided the Plan determines that Benefits are available upon receipt of a claim.** This reduction applies *in addition* to any Benefit reduction associated with the use of an Out-of-Network Provider, if applicable. For Inpatient services received outside of our service area, see the section entitled, "The BlueCard® Program" in ***General Provisions***.

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

Preauthorization Process for Inpatient Psychiatric Care Services

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

Preauthorization Requests Involving Emergency Care

If a Covered Person is admitted to the Hospital for Emergency Care and there is not time to obtain Preauthorization, the Covered Person will not be subject to the Preauthorization "penalty" (if any) outlined in their Policy, *if they or their Provider notifies the Plan within two business days following the emergency admission.*

Preauthorization Process for Certain Outpatient Services

A Covered Person must request Preauthorization from the Plan at least two business days prior to receiving any of the following **Outpatient** services:

- Outpatient Surgery performed at a Hospital or Ambulatory Surgical Facility (Out-of-Network Services only);
- Dialysis Treatment (Out-of-Network Services only);
- Hospice Services;
- Home Health Care Services;

- Private Duty Nursing Services;
- Molecular genetic testing;
- Radiation Therapy;
- Home Infusion Therapy;
- Human Organ and Tissue Transplant services;
- Home Hemodialysis;
- Medically Necessary reconstructive Surgery;
- Outpatient Provider administered drug therapies, Cellular Immunotherapy, and Gene Therapy; and any of the following Psychiatric Care Services:
  (1) Psychological testing;
  (2) Neuropsychological testing;
  (3) Electroconvulsive therapy;
  (4) Intensive Outpatient Treatment;
  (5) Repetitive Transcranial Magnetic Stimulation; and

The following additional Outpatient procedures/services:

- **Cardiac (heart related):**
  Lipid Apheresis.
- **Ears, Nose and Throat (ENT):**
  Bone Conduction Hearing Aids;
  Cochlear Implant;
  Nasal and Sinus Surgery.
- **Gastroenterology (Stomach):**
  Gastric Electrical Stimulation (GES).
- **Neurological:**
  Deep Brain Stimulation;
  Sacral Nerve Neuromodulation/Stimulation;
  Vagus Nerve Stimulation (VNS).
- **Orthopedic (Musculoskeletal):**
  Artificial Intervertebral Disc;
  Autologous Chondrocyte Implantation (ACI) for Focal Articular Cartilage Lesions;
  Femoroacetabular Impingement (FAI) Syndrome;
  Functional Neuromuscular Electrical Stimulation (FNMES);
  Joint and Spine Surgery;
  Lumbar Spinal Fusion;
  Meniscal Allografts and Other Meniscal Implants;
  Orthopedic Applications of Stem-Cell Therapy.
- **Pain Management:**
  Occipital Nerve Stimulation;
  Surgical Deactivation of Headache Trigger Sites;
  Interventional Pain Management;
  Percutaneous and Implanted Nerve Stimulation and Neuromodulation;
  Spinal Cord Stimulation.

- **Radiology:**
  Advanced Imaging Services: MRI, Magnetic Resonance Angiogram (MRA), PET, PET-CT, CT, Computed Tomography Angiography (CTA), Nuclear Medicine.
- **Surgical Procedures:**
  Orthognathic Surgery; Face reconstruction;
  Mastopexy; Breast lift;
  Reduction Mammoplasty; Breast Reduction.
- **Wound Care:**
  Hyperbaric Oxygen (HBO2) Therapy.

For specific details about the Preauthorization requirement for the above referenced services, please call the Customer Service number on the back of your Identification Card. The complete list of Covered Services requiring Preauthorization is subject to review and change by Blue Cross and Blue Shield of Oklahoma. The Plan reserves the right to no longer require Preauthorization during the Benefit Period for any or all the above listed Outpatient services.

Failure to Preauthorize

If the Covered Person does not call for Preauthorization for **Inpatient services, Home Health Care Services or Hospice Services, listed above,** these services will be subject to a $500 reduction in Benefits if, upon receipt of a claim, it is determined by the Plan that the services were Medically Necessary. If it is determined that the services were not Medically Necessary or were Experimental, Investigational and/or Unproven, it may be the Covered Person's responsibility to pay the full cost of the services received.

If the Covered Person fails to obtain Preauthorization for the other Outpatient services listed above:

- The Plan will review the Medical Necessity of the treatment or service prior to the final Benefit determination;
- If the Plan determines the treatment or service is not Medically Necessary or is Experimental, Investigational and/or Unproven, Benefits will be reduced or denied.

Please keep in mind that any treatment a Covered Person receives which is not a Covered Service under this Policy, or is not determined to be Medically Necessary, will be excluded from their Benefits. This Preauthorization approval is requested or received.

Response to Preauthorization Requests

The Plan will provide a written response to a Covered Person's Preauthorization request no later than 15 days following the date we receive the request. This period may be extended one time for up to 15 additional days, if we determine that additional time is necessary due to matters beyond our control.

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

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

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

Response to Preauthorization Requests Involving Urgent Care

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

- could seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain mum function; or
- in the opinion of a Physician with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Preauthorization request.

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

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

Please keep in mind that any treatment a Covered Person receives which is not a Covered Service under this Policy, or is not determined to be Medically Necessary, will be excluded from the Covered Person's Benefits. This applies even if Preauthorization approval is requested or received.

Effective Date of Coverage

Insurance for an Eligible Person who enrolls during the program's enrollment period, as established by the school, is effective on the latest of the following dates:

- the Policy Effective Date;
- the date the completed online enrollment form is received;
- the date after the required premium is paid; or
- the date the Student enters the Eligible Class.

After the time periods described above, the Student must wait until the next enrollment period, except for a newborn or a newly adopted child or if there is an involuntary loss of coverage under another health care plan.

We will pay Benefits for a newborn child of a Covered Person until that child is 31 days old.

Adopted children, as defined by the Policy, will be covered on the same basis as a newborn child from the date the child is Placed for Adoption with the Student or the date the Student becomes a party to a suit for the adoption of the child. Coverage will cease on the date the child is removed from placement and the Student's legal obligation terminates.

Coverage for newborn and adopted children will consist of coverage for covered Injury or covered Sickness including the necessary care and treatment of medically diagnosed congenital defects, prematurity, well baby care, birth abnormalities, and Routine Nursery Care related with a covered Sickness.

OPEN ENROLLMENT PERIODS

The Plan along with the Institution will designate open enrollment periods during which Students may apply for or change coverage for himself/herself.

This section "*Open Enrollment Periods*" is subject to change by the Plan, and/or applicable law, as appropriate.

QUALIFYING EVENT

Eligible Students who have a change in status and lose coverage under another health care plan are eligible to enroll for coverage under this Policy. Within 31 days of the qualifying event, such Student must complete the online qualifying event form, provide a letter of ineligibility, and pay any additional premium. Go to www.bcbsok.com, click on 'Shop for Student Health Plans' and select your university for more information. 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, gain of a Dependent whether by birth, adoption, or Placement for Adoption or court-ordered Dependent coverage, or loss of Dependent status because of age. The premium will be the same as it would have been at the beginning of the semester or quarter, whichever applies. However, the Policy Effective Date will be the later of the date the Student enrolls for coverage under the Policy and pays the required premium, or the day after the prior coverage ends.

Discontinuance of Insurance

TERMINATION DATE OF INSURANCE

A Student's coverage will end on the earliest of the date:

- the Policy terminates;
- the Student is no longer eligible; or
- the period ends for which premium is paid.

REFUND OF PREMIUM

A pro-rata refund of premium will be made only in the event:

- of a Covered Person's death; or
- a covered Person ceases to maintain eligibility; or
- the Covered Person enters full-time active duty in any Armed Forces; and
- we receive proof of such active duty service.

Accident & Sickness Medical Expense Benefits

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

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

PREVENTIVE CARE SERVICES

NOTE: Preventive Care Services received from Network or BlueCard Providers are not subject to Deductible, Copayment, Coinsurance and/or dollar maximums. Preventive Care Services received from Out-of-Network Providers may be subject to Deductible, Copayment and/or Coinsurance, except for certain state or federally mandated Benefits (for example: covered childhood immunizations for Covered Persons under age 19).

Benefits will be provided for any of the following Covered Services performed by a Provider:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF");
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved;
- Evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") for infants, children, and adolescents; and
- With respect to women, such additional preventive care and screenings, not described in item 1 above, as provided for in comprehensive guidelines supported by the HRSA. Such services will include the following:
- Breast-feeding Support, Services and Supplies – Benefits will be provided for breast-feeding counseling and support services rendered by a Provider for pregnant and postpartum women. Benefits include the rental (or, at the Plan's option, the purchase) of manual or electric breast-feeding equipment, limited to one electric breast pump per Benefit Period.
- Contraceptive Services – Benefits will be provided for the following contraceptive services when prescribed by a licensed Provider for women with reproductive capacity:
  (1) contraceptive counseling;
  (2) FDA-approved prescription devices and medications;
  (3) over-the-counter contraceptives; and
  (4) sterilization procedures (including, but not limited to, tubal ligation), but not including hysterectomy.
- Coverage includes contraceptives in the following categories:
  (1) progestin-only contraceptives;
  (2) combination contraceptives;
  (3) emergency contraceptives;
  (4) extended-cycle/continuous oral contraceptives;
  (5) cervical caps;
  (6) diaphragms;
  (7) implantable contraceptives;
  (8) intra-uterine devices;

(9) injectables;
(10)transdermal contraceptives; and
(11)vaginal contraceptive devices.

NOTE: Prescription contraceptive medications are covered under ***Outpatient Prescription Drugs and Related Services***, *if applicable*.

The contraceptive drugs and devices listed above may change as FDA guidelines are modified. Deductible, Copayment and/or Coinsurance amounts will not apply to FDA-approved contraceptive drugs and devices on the Contraceptive Drug List. To determine if a specific drug is on the Contraceptive Drug List, a Covered Person may access the Web site at *www.bcbsok.com* or contact Customer Service at the toll-free number on their Identification Card.

When obtaining the items noted above, Covered Persons may be required to pay the full cost and then submit a claim form with itemized receipts to the Plan for reimbursement. Please refer to ***Claim Provisions*** for claims submission information.

Covered Preventive Care Services received from Out-of-Network Providers and/or Out-of-Network Pharmacies, or other routine Covered Services not provided for under this provision may be subject to any Deductibles, Copayments, Coinsurance and/or Benefit maximums applicable to a Covered Person's coverage.

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

Preventive Care Services will be implemented in the quantities and within the time periods allowed under applicable law. The Preventive Care Services described in items 1 through 4 above may change as the USPSTF, CDC, and HRSA guidelines are modified. For more information Covered Persons may access the Web site at *www.bcbsok.com* or contact Customer Service at the toll-free number listed on their Identification Card.

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

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

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

NOTE: Tobacco cessation medications are covered under ***Outpatient Prescription Drugs and Related Services*** when prescribed by a Network Provider.

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

Covered Services ***not*** included in items listed above may be subject to any Deductibles, Copayments**,** Coinsurance and/or Benefit dollar maximums applicable to a Covered Person's coverage.

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

Coverage for the Preventive Care Services specified in items 1 through 3 above shall be provided in accordance with the terms and conditions of the appropriate Benefit section of this Policy (for example: "Inpatient Services", "Outpatient Services", "Other Services" or ***Outpatient Prescription Drugs and Related Services***).

EMERGENCY CARE SERVICES

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

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

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

Services provided in an emergency room that are not Emergency Care may be excluded from emergency coverage, although these services may be covered under another benefit, if applicable. Non-emergency services provided in an emergency room for treatment of Mental Illness or substance abuse disorder will be paid the same as Emergency Care services.

HOSPITAL SERVICES

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

- **Bed and Board**

  Bed, board and general nursing service in:
  (1) A room with two or more beds;
  (2) A private room (private room allowance is equal to the most prevalent semiprivate room charges of the Covered Person's Hospital). Private room charges in excess of the semiprivate room allowance will not be eligible for Benefits unless the patient is required under the infection control policy of the Hospital to be in isolation to prevent contagion;
  (3) A bed in a Special Care Unit which gives intensive care to the critically ill.

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

- **Ancillary Services**
  (1) Operating, delivery and treatment rooms;
  (2) Prescribed drugs;
  (3) Whole blood, blood processing and administration;
  (4) Anesthesia supplies and services rendered by an employee of the Hospital or other Provider;
  (5) Medical and surgical dressings, supplies, casts and splints;
  (6) Oxygen;
  (7) Subdermally implanted devices or appliances necessary for the improvement of physiological function;
  (8) Diagnostic Services;
  (9) Therapy Services.
- **Emergency Accident Care**
  Outpatient emergency Hospital services and supplies to treat injuries caused by an Accident.
- **Emergency Medical Care**
  Outpatient emergency Hospital services and supplies to treat a sudden and acute medical condition that requires prompt Medical Care.
- **Surgery**
  Hospital services and supplies for Outpatient Surgery furnished by an employee of the Hospital or other Provider other than the surgeon or assistant surgeon.
- **Routine Nursery Care**
  (1) Inpatient Hospital Services for Routine Nursery Care of a newborn Covered Person.
  (2) Routine Nursery Care provided within the first 31 days after birth, including treatment of diagnosed congenital and birth abnormalities.

SURGICAL/MEDICAL SERVICES

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

- **Surgery**
  Benefits include visits before and after Surgery.
  (1) If an incidental procedure[1] is carried out at the same time as a more complex primary procedure, then Benefits will be **available** for only the primary procedure. **Separate Benefits will not be available for any incidental procedures performed at the same time.**
  (2) When more than one surgical procedure is performed through more than one route of access during one operation, the Covered Person is covered for:
    (a) the primary procedure; plus
    (b) 50% of the amount available for each of the additional procedures had those procedures been performed alone.

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

(c) miscellaneous surgical services

(3) Sterilization, regardless of Medical Necessity.

- **Assistant Surgeon**

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

- **Anesthesia**

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

- **Inpatient Medical Services**

  Medical Care when the Covered Person is an Inpatient for a condition not related to Surgery, pregnancy or Mental Illness, except as specified.

  (1) Inpatient Medical Care Visits

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

  (2) Intensive Medical Care

  Constant Physician attendance and treatment when the Covered Person's condition requires it for a prolonged time.

  (3) Concurrent Care

  (a) Care for a medical condition by a Physician who is not the Covered Person's surgeon while they are in the Hospital for Surgery.

  (b) If the nature of the illness or Injury requires, care by two or more Physicians during one Hospital stay.

- **Consultation**

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

- **Newborn Well Baby Care**

  Routine Nursery Care visits to examine a newborn Covered Person.

- **Outpatient Medical Services**

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

  – Emergency Accident Care

  Treatment of accidental bodily injuries.

  – Emergency Medical Care

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

  – Home, Office and Other Outpatient Visits.

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

  – Virtual Visits

  Covered Services provided via consultation with a licensed Provider through interactive video, or other communication technology allowed by applicable law, via online portal or mobile application. Virtual Visits provide access to Providers who can provide diagnosis and treatment of non-emergency medical and Mental Illness conditions in situations that may be handled without a traditional office visit, Urgent Care visit or Emergency Care visit.

- Contraceptive Devices

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

  Audiological services and hearing aids, limited to:
  - **One hearing aid per ear every 48 months; and**
  - **Up to four additional ear molds per Benefit Period if Medically Necessary.**

  Hearing aids must be prescribed, filled and dispensed by a licensed audiologist or other Provider acting within the scope of their license.

OUTPATIENT DIAGNOSTIC SERVICES

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

OUTPATIENT THERAPY SERVICES

- Radiation Therapy

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

  Outpatient Therapy Services do not include oral Chemotherapy or self-injectable/self-administered Chemotherapy. These Prescription Drugs may be covered under the *Outpatient Prescription Drugs and Related Services* under this Policy.
- Respiratory Therapy
- Dialysis Treatment
- Infusion Therapy
- Physical Therapy, Occupational Therapy and Speech Therapy

  Benefits for Outpatient Physical Therapy, Outpatient Occupational Therapy and Outpatient Speech Therapy (including visits to the Covered Person's home) are limited to the number of visits specified in the *Schedule of Benefits* in the front of this Policy. This visit limit is not applicable to Therapy Services for treatment of autism and autism spectrum disorder.

MATERNITY SERVICES

Hospital Services and Surgical/Medical Services from a Provider for:

- Normal Pregnancy

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

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

- Interruptions of Pregnancy
  - Miscarriage.
  - Abortion, when the life of the mother is endangered.

Covered Maternity Services include the following:

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

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

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

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

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

MASTECTOMY AND RECONSTRUCTIVE SURGICAL SERVICES

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

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

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

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

HUMAN ORGAN, TISSUE AND BONE MARROW TRANSPLANT SERVICES

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

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

- **Definitions**

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

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

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

- **High−Dose Chemotherapy**

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

- **High−Dose Radiation Therapy**

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

- **Preauthorization**

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

- **Procurement Services**

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

- **Transplant Services**

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

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

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

  If a human organ, tissue or Bone Marrow Transplant is provided from a ***living*** donor to a human transplant recipient:
  - When both the recipient and the living donor are Covered Persons, each is entitled to the Benefits of this Policy.
  - When only the recipient is a Covered Person, both the donor and the recipient are entitled to the Benefits of this Policy. The donor Benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage or other Blue Cross or Blue Shield coverage or any government program. Benefits provided to the donor will be applied to the recipient's coverage under this Policy.
  - When only the living donor is a Covered Person, the donor is entitled to the Benefits of this Policy. The Benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage or other Blue Cross or Blue Shield coverage or any government program available to the recipient. There are no Covered Services for the non−Covered Person transplant recipient.
  - If any organ or tissue or bone marrow or stem cells or progenitor cells are sold rather than donated to the Covered Person recipient, no Covered Services will be provided for the purchase price, evaluation, Procurement Services or procedure.

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

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

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

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

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

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

  – The Bone Marrow Transplant is not excluded by another provision of this Policy.

AMBULATORY SURGICAL FACILITY SERVICES

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

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

SERVICES RELATED TO TREATMENT OF AUTISM AND AUTISM SPECTRUM DISORDERS

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

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

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

Applied Behavior Analysis is subject to the "Preauthorization" requirements set forth in the Important Information section of this Contract. If you fail to comply with these requirements, Benefits for Covered Services may be reduced or denied.

- Medications prescribed by a licensed Physician and any health-related services deemed Medically Necessary

to determine the need or effectiveness of the medications.

- Direct or consultative services provided by a psychiatrist or psychologist licensed in the state in which the psychiatrist or psychologist practices.
- Therapeutic care services provided by licensed or certified speech therapists, occupational therapists, or physical therapists. Speech Therapy, Physical Therapy and Occupational Therapy visits related to treatment of Autism Spectrum Disorder are not subject to the limitations specified under "Outpatient Therapy Services".

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

PSYCHIATRIC CARE SERVICES

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

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

- Inpatient Facility Services

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

- Inpatient Medical Services

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

  – Medical Care visits **limited to one visit or other service per day;**
  – Individual Psychotherapy;
  – Group Psychotherapy;
  – Psychological Testing; and
  – Convulsive Therapy Treatment.
  – Electroshock treatment or convulsive drug therapy including anesthesia when rendered together with treatment by the same Physician or other Provider.

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

- Outpatient Psychiatric Care Services

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

- Drug Addiction, Substance Abuse and Alcoholism

  The Covered Person's Benefits for the treatment of Mental Illness include treatments for drug abuse, substance abuse and alcoholism.

AMBULANCE SERVICES

- Payment will be made to the Provider as shown in the ***Schedule of Benefits***. Medically Necessary transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured:
  - From a Covered Person's home to a Hospital;
  - From the scene of an Accident or medical emergency to a Hospital;
  - Between Hospitals;
  - Between a Hospital and a Skilled Nursing Facility; or
  - From the Hospital to a Covered Person's home.
- Ambulance Services means local transportation to the ***closest facility*** appropriately equipped and staffed for treatment of the Covered Person's condition. If none, they are covered for trips to the closest such facility outside their local area.
- Ambulance Services for non-Emergency Care may be covered when, in addition to the above requirements, the Covered Person's condition is such that any other form of transportation would be medically contraindicated.
- Air ambulance services are covered only when:
  - Air ambulance services are Medically Necessary; and
  - Terrain, distance, a Covered Person's physical condition or other circumstances require the use of air ambulance services rather than ground ambulance services.

PRIVATE DUTY NURSING SERVICES

Services of a practicing RN, LPN or LVN when ordered by a Physician and when Medically Necessary. The nurse cannot be a member of the Covered Person's Immediate Family or usually live in their home.

Benefits for Private Duty Nursing Services are limited to the number of visits specified in the *Schedule of Benefits* in the front of this Policy.

Private Duty Nursing Services are subject to the *"Preauthorization"* requirements of this Policy (see *Important Information* section). If you fail to comply with these requirements, Benefits for Covered Services may be reduced or denied.

REHABILITATION CARE/HABILITATION CARE

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

Benefits for Rehabilitation Care/Habilitation Care are limited to the number of visits specified in the *Schedule of Benefits* in the front of this Policy.

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

SKILLED NURSING FACILITY SERVICES

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

Benefits for Skilled Nursing Facility Services are limited to the number of visits specified in the *Schedule of Benefits* in the front of this Policy.

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

No Benefits are available:

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

HOME HEALTH CARE SERVICES

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

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

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

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

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

The Plan does not pay Home Health Care Benefits for:

- Dietitian services, except as specified for diabetes self-management training;
- Homemaker services;
- Maintenance therapy;
- Speech Therapy;
- Durable Medical Equipment;
- Food or home-delivered meals;
- Infusion Therapy, **except when the Covered Person has received Preauthorization from the Plan for these services.**

HOSPICE SERVICES

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

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

DENTAL SERVICES FOR ACCIDENTAL INJURY

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

DIABETES EQUIPMENT, SUPPLIES AND SELF-MANAGEMENT SERVICES

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

- Visits Medically Necessary upon the diagnosis of diabetes;
- A Physician diagnosis which represents a significant change in the patient's symptoms or condition making Medically Necessary changes in the patient's self-management; and
- Visits when reeducation or refresher training is Medically Necessary.

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

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

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

SERVICES RELATED TO CLINICAL TRIALS

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

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

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

For purposes of this provision, "Routine Patient Costs" generally include all items and services consistent with the coverage provided under this Policy 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 clinical management of the patient; or
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

DURABLE MEDICAL EQUIPMENT

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

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

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

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

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

PROSTHETIC APPLIANCES

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

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

ORTHOTIC DEVICES

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

Benefits will be provided for the following orthotic devices:

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

- Trusses.

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

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

Benefits for orthotic devices are limited to the maximum amount specified in the *Schedule of Benefits* in the front of this Policy.

WIGS OR OTHER SCALP PROTHESES

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

Benefits are limited to the maximum amount specified in the *Schedule of Benefits* in the front of the Policy.

- Preferred Network Provider Pharmacies: Although a Covered Person can go to the Pharmacy of his or her choice, a Covered Person's Benefits for drugs and supplies will be greater when they obtain them from a Preferred Network Provider Pharmacy. Covered Persons can visit the Plan's Web site at *www.bcbsok.com* for a list of Preferred Network Provider Pharmacies or call the Customer Service toll-free number on their Identification Card. The Pharmacies that are Preferred Network Pharmacies may change from time to time. A Covered Person should check with the Pharmacy before obtaining drugs or supplies to make certain of its participation status.
- Drugs (including both prescription and over-the-counter) that fall within a category of the current "A" or "B" recommendations of the United States Preventive Services Task Force and that are listed on the ACA Preventive Services Drug List (to be implemented in the quantities and within the time period allowed under applicable law) will be covered and will not be subject to any Copayment Amount, Coinsurance Amount, Deductible, or dollar maximum when obtained from a Participating Pharmacy. Drugs on the Preventive Services Drug List that are obtained from a non-Participating Pharmacy, may be subject to Copayment Amount, Coinsurance Amount, Deductibles, or dollar maximums, if applicable.
- Drug List: The Benefit for drugs listed on the Drug List are selected by the Plan based upon the recommendations of a committee, which is made up of current and previously practicing Physicians and pharmacists from across the country, some of whom are employed by or affiliated with the Plan. The committee considers drugs regulated by the FDA for inclusion on the Drug List. As part of the process, the committee reviews data from clinical studies, published literature and opinions from experts who are not part of the committee. Some of the factors committee members evaluate include each drug's safety, effectiveness, cost and how it compares with drugs currently on the Drug List. The committee considers drugs that are newly approved by the FDA, as well as those that have been on the market for some time. Entire drug classes are also regularly reviewed. Changes to this list can be made from time to time. The Plan may offer multiple formularies. Covered Persons will be able to determine the Drug List that applies to them and whether a particular drug is on the Drug List. Drugs that appear on the Drug List as Non-Preferred Brand Name Drugs are subject to the Non-Preferred Brand Name Drug payment level plus any pricing differences that may apply to the Covered Drug a Covered Person receives.
- Drug List Exception Requests: You or your Provider can ask for a Drug List Exception if your drug is not on the Drug List. To request this exception, you or your Provider can call the number on the back of your Identification Card to ask for a review. If you have a health condition that may jeopardize your life, health, or keep you from regaining function, or your current drug therapy uses a non-Covered Drug, you or your Provider may be able to ask for an expedited review process. The Plan will let you and your Provider know the coverage decision within 72 hours after the Plan received your request for an expedited review. If the coverage request is denied, we will let you and your Provider know why it was denied and offer you a covered alternative drug (if applicable). If your exception is denied, the denial determination will include information explaining the appeals process. Call the number on the back of your Identification Card if you have any questions.
- Preauthorization: Certain Prescription Drugs require a drug's prescribed use to be evaluated against a predetermined set of criteria to determine Medical Necessity before the prescription will be covered. If the approval is not granted, the Covered Person may appeal the decision.
- Step Therapy: When the Covered Person buys a Prescription Drug which has a more cost-effective option in the same therapeutic class and is recommended by the pharmacist, coverage will be limited to the cost of the more cost-effective drug.

- Dispensing Limits: If a Prescription Order is written for a certain quantity of medication to be taken in a time period directed by a Provider, coverage will only be provided for a clinically appropriate pre-determined maximum quantity of medication for the specified amount of time. Dispensing Limits are based upon FDA dosing recommendations and nationally recognized clinical guidelines.
- Benefits will not be provided for a prescription refill until 75% of the previous Prescription Order (or 70% for covered prescription eyedrops) has been used by the Covered Person. An exception for this provision may be granted on at least one occasion per year to synchronize your Prescription Drug refills for certain covered maintenance medications so that they are refilled on the same schedule for a given time period. When necessary to permit synchronization, the Plan shall apply a prorated daily cost-sharing rate to any covered medication dispensed by a Preferred Network Pharmacy.
- Split-Fill Program: If this is your first time using select medications or you have not filled one of these medications recently, you may only be able to receive a partial fill (14 – 15 day supply) of the medication for up to the first 3 months of therapy. This is to help see how the medication is working for you. Your cost-share may be adjusted to align with the number of pills dispensed. If the medication is working for you and your Physician wants you to continue on this medication, you may be eligible to receive up to a 30-day supply after completing up to 3 months of the partial supply.
- Controlled Substance Limitation: If the Plan determines that a Covered Person may be receiving quantities of controlled substance medications not supported by FDA approved dosages or recognized safety treatment guidelines, Benefits may be subject to a review to determine Medical Necessity, appropriateness and other restrictions such as limiting coverage to services provided by a certain Provider and/or Participating Pharmacy for the prescribing and dispensing of the controlled substance medication and/or limiting coverage to certain quantities. For the purposes of this provision, controlled substance medications are medications classified and restricted by state or federal laws.
- Out-of-Network Pharmacies: When a Covered Person obtains Prescription Drugs, including diabetic supplies from an Out-of-Network Pharmacy (other than a Network Pharmacy), Benefits will be provided at 60% of the amount a Covered Person would have received had he/she obtained drugs from a Network Pharmacy minus the Copayment amount or Coinsurance amount.
- Specialty Drugs: In order to receive maximum Benefits for Specialty Drugs, a Covered Person must obtain the Specialty Drugs from the preferred Specialty Pharmacy Provider. Specialty Drugs obtained from all other Pharmacies will be payable at the Out-of-Network Provider Pharmacy Benefit level.
- Deductible: If a Covered Person is responsible for a Coinsurance amount, each Benefit Period he/she must satisfy the Network Provider program Deductible described in the ***Schedule of Benefits*** for a Covered Person's medical Benefits before a Covered Person's Benefits will begin for drugs and diabetic supplies. Expenses incurred by a Covered Person for Covered Services under this section will also be applied towards the program Deductible.
- If a covered Prescription Drug was paid for using a drug manufacturer's coupon or copayment card, the coupon or copayment card amount will not apply to your Deductible or Out-of-Pocket Maximum.

INJECTABLE DRUGS

Benefits are available for Medically Necessary injectable drugs which are self-administered that require a written prescription by federal law. Benefits will not be provided for any self-administered drugs dispensed by a Physician.

DIABETIC SUPPLIES FOR TREATMENT OF DIABETES

Benefits are available for Medically Necessary items of diabetic supplies for which a Provider has written an order. Such diabetes supplies shall include, but are not limited to, the following:

- Test strips specified for use with a corresponding blood glucose monitor;
- Glucose test solutions;
- Glucagon;
- Glucose tablets;
- Lancets and lancet devices;
- Visual reading strips and urine testing strips and tablets which test for glucose, ketones, and protein;
- Insulin and insulin analog preparations;
- Injection aids, including devices used to assist with insulin injection and needleless systems;
- Insulin syringes;
- Prescriptive and non-prescriptive oral agents for controlling blood sugar levels;
- Glucagon emergency kits.

Note: The amount you may pay for a covered insulin drug shall not exceed $30 per 30-day supply or $90 per 90-day supply.

VACCINATIONS OBTAINED THROUGH NETWORK PHARMACIES

Benefits for vaccinations are available through certain Network Pharmacies that have contracted with Blue Cross and Blue Shield of Oklahoma to provide this service. To locate one of these contracting Network Pharmacies in a Student's area and to find out which vaccinations are covered, the Covered Person can call Customer Service at the number on the back of their Identification Card or access the Web site at *www.bcbsok.com*.

Each Network Pharmacy that has contracted with the Plan to provide this service may have age, scheduling, or other requirements that will apply, so Covered Persons are encouraged to contact them in advance. Childhood immunizations subject to state regulations are not available under this Policy's Outpatient Prescription Drug Benefits. A Covered Person can refer the Plan's medical coverage for Benefits available for childhood immunizations.

Benefits for vaccinations that are considered Preventive Care Services will not be subject to any Deductible, Coinsurance, Copayment or dollar maximum when such services are received from a Network Provider or Network Pharmacy that is contracted for such service.

Vaccinations that are received from an Out-of-Network Provider, or Out-of-Network pharmacists, or other routine Covered Services not provided for under this provision may be subject to the Deductible, Coinsurance, Copayments and/or Benefit maximums.

THERAPEUTIC EQUIVALENT RESTRICTIONS

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

EXCLUSIONS AND LIMITATIONS

- Prescription Drug coverage is not provided for:
  - refills in excess of the number specified or dispensed after one year from the date of the prescription;
  - drugs labeled "Caution - Limited by Federal Law to Investigational Use", or Experimental, Investigational and/or Unproven drugs;
  - immunizing agents, biological sera, blood or blood products administered on an Outpatient basis, except as specifically provided in this Policy;
  - 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;
  - nonsedating 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 customized medications made by mixing, assembling, packaging or labeling drugs that are not commercially available in a specific dosage form, strength or formulation;
  - drugs determined by the Plan to have inferior efficacy or significant safety issues;
  - 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;
  - 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;
  - any portion of Covered Services or Covered Drugs paid for through Pharmacy coupons, drug cards or rebates.
  - drugs which are not included on the Drug List unless specifically covered elsewhere in this Policy and/or such coverage is required in accordance with applicable law or regulatory guidance.

Some drugs have therapeutic equivalents/therapeutic alternatives. In some cases, Blue Cross and Blue Shield may limit Benefits to only certain therapeutic equivalents/therapeutic alternatives. If you do not choose the therapeutic equivalents/therapeutic alternatives that are covered under your Benefit, the drug purchased will not be covered under any Benefit level.

Exclusions and Limitations

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

- services that are not Medically Necessary or charges in excess of the Allowable Charge;
- services that are provided, normally without charge, by the Student Health Center, infirmary or Hospital, or by any person employed by the University;
- acupuncture procedures;
- bio-feedback procedures;
- breast augmentation or reduction;
- routine circumcision, unless the procedure is Medically Necessary for treatment of a Sickness, disease or functional congenital disorder not excluded hereunder or as may be necessitated due to an Accident or except for covered infants within 28 days of birth;
- any charges for Surgery, procedures, treatment, facilities, supplies, devices or drugs that the Plan determines are Experimental, Investigational and/or Unproven;
- any illness or Injury occurring in the course of employment if whole or partial compensation or benefits are or might have been available under the laws of any governmental unit; any policy of workers' compensation insurance; an employer's insured and/or self-funded workers' compensation plan or any other plan providing coverage for work-related illness or Injury; or according to any recognized legal remedy arising from an employer-employee relationship. This applies whether or not a Covered Person claims the benefits or compensation or recovers the losses from a third party.
  - The Covered Person agrees 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 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:
    - 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 their employer or insurance carrier.
- treatment, services or supplies in a Veteran's Administration or Hospital owned or operated by a national government or its agencies unless there is a legal obligation for the Covered Person to pay for the treatment;
- testing for or treatment of allergies;
- services, supplies or charges related to Inpatient treatment of any non-covered dental procedure, except that coverage shall be provided for Hospital Services, Ambulatory Surgical Facility Services, and anesthesia services associated with any Medically Necessary dental procedure when provided to a Covered Person who is severely disabled; or who has a medical or emotional condition which requires hospitalization or general anesthesia for dental care; or who, in the judgment of the treating practitioner, is not of sufficient emotional development to undergo a Medically Necessary dental procedure without the use of anesthesia.

- expenses in connection with services and prescriptions for eye examinations, eye refractions, eyeglasses or contact lenses, or the fitting of eyeglasses or contact lenses radial keratotomy or laser Surgery for vision correction or the treatment of visual defects or problems, except for pediatric vision;
- cosmetic Surgery or complications resulting therefrom, including Surgery to improve or restore a Covered Person's appearance, unless:
  - needed to repair conditions resulting from an accidental Injury; or
  - for the improvement of the physiological functioning of a malformed body member resulting from a congenital defect.

  In no event will any care and services for breast reconstruction or implantation or removal of breast prostheses be a Covered Service unless such care and services are performed solely and directly as a result of mastectomy which is Medically Necessary.
- riding as a passenger or otherwise in any vehicle or device for aerial navigation except as a fare-paying passenger in an aircraft operated by a commercial scheduled airline;
- Injuries arising from Interscholastic Activities and Qualifying Intercollegiate Sports;
- Injury resulting from racing or speed contests, skin diving, sky diving, parachuting, hang gliding, glider flying, parasailing, sail planing, bungee jumping, mountaineering (where ropes or guides are customarily used), or any other hazardous sport or hobby;
- war or acts of war, whether declared or undeclared, when serving in the military or an auxiliary unit thereto;
- elective abortion, unless the life of the mother is endangered;
- reverse sterilization;
- treatment of sexual dysfunction not caused by organic disease;
- reproductive/infertility procedures and fertility tests, including but not limited to: family planning, fertility tests, infertility (male or female), including any supplies rendered for the purpose or with the intention of achieving conception; premarital examinations. Examples of fertilization procedures are: ovulation induction; in vitro fertilization; embryo transplant; or similar procedures that augment or enhance the Covered Person's reproductive ability;
- services for or related to transplantation of donor organs, tissues or bone marrow, except as specified under "*Human Organ, Tissue and Bone Marrow Transplant Services*";
- expenses incurred for dental care or treatment of the teeth, gums or structures directly supporting the teeth, including surgical extractions of teeth. This exclusion does not apply to the repair of Injuries to sound natural teeth caused by a covered Injury;
- foot care including: flat foot conditions, supportive devices for the foot, subluxations, care of corns, bunions (except capsular or bone Surgery), calluses, toenails, fallen arches, weak feet, foot strain, and symptomatic complaints of the feet, except those related to diabetic care;
- services for hearing aids, tinnitus maskers, or examinations for prescribing or fitting them, except as specified under "Audiological Services". Hearing examinations not related to the prescription or fitting of hearing aids will be a Covered Service only when performed in connection with the diagnosis or treatment of disease or Injury, or as specified under *"Preventive Care Services";*
- weight management, weight reduction, or treatment for obesity including any condition resulting therefrom, including hernia of any kind;
- treatment of obesity, including morbid obesity, regardless of the patient's history or diagnosis, including but not limited to the following: weight reduction or dietary control programs; 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;

- Surgery for the removal of excess skin or fat;
- nutrition programs, except as related to treatment for diabetes;
- weight loss programs, except as related to treatment for diabetes;
- Custodial Care;
- long term care services;
- treatment of temporomandibular joint dysfunction, including but not limited to diagnostic procedures, splints, orthodontic/orthopedic appliances, restorations necessary to increase vertical dimension or to restore or maintain functional or centric occlusion, alteration of teeth or jaws, Physical Therapy and medication and behavioral modification related to conditions of temporomandibular joint syndrome or any other conditions involving the jaw joint, adjacent muscles or nerves, regardless of cause or diagnosis;
- smoking cessation programs, not including counseling as specified under *"Preventive Care Services"*.
- services for transportation services, except as described under *"Ambulance Services"* in ***Accident & Sickness Medical Expense Benefits***.
- drugs which are not included on the Drug List unless specifically covered elsewhere in this Policy and/or such coverage is required in accordance with applicable law or regulatory guidance.

NON-DUPLICATION OF BENEFITS

If Benefits are payable under more than one Benefit provision contained in the Policy, Benefits will be payable only under the provision providing the greater Benefit.

Pediatric Vision Care

This section provides information about coverage for the routine vision care services outlined below, which are specifically excluded under a Covered Person's medical Benefits in this Policy. Services that are covered in a Covered Person's medical Benefits in this Policy are not covered under this section. All provisions in this Policy apply to this section unless specifically indicated otherwise below.

The Plan has partnered with EyeMed Vision Care, LLC ("EyeMed") to administer the Benefits provided under this section. EyeMed provides customer service and claims administration services to our Covered Persons and allows Covered Persons access to their extensive network of vision care Providers.com.

This vision care coverage allows Covered Persons to select the Provider of their choice, in or out of the Vision Care Provider Network. The Plan has designed these Benefits to deliver quality care, matched with the Covered Person's medical Benefits, at the most affordable cost, through network services. The Covered Person also has the flexibility to visit an Out-of-Network Provider, with a reduction in Benefits.

A. DEFINITIONS

- **Provider – For purposes of this section,** a licensed ophthalmologist or optometrist operating within the scope of his/her license, or a dispensing optician.

  NOTE: If a Covered Person uses the services of any member of the Healing Arts who is licensed by any state of the United States or its territories to perform services within the scope of his/her license which, if performed by a Physician, optometrist, or optician, would be considered eligible for Benefits under this Policy, then Benefits will be provided regardless of which healing art performs the service.
- **Vision Care Network Provider –** A Vision Care Network Provider is a Provider who has contracted with the Plan or EyeMed to provide services under this section. An "Out-of-Network" Provider has not contracted with the Plan or EyeMed (*even if such Provider is contracted with the Plan to render Covered Services under a Covered Person's medical Benefits*).
- **Vision Materials –** Corrective lenses and/or frames or contact lenses.

B. ELIGIBILITY

Children who are covered under this Policy, up to age 19, are eligible for vision coverage under this section. NOTE: Once coverage is lost under the Policy, all Benefits cease under this section.

C. SCHEDULE OF BENEFITS

The following ***Schedule of Benefits*** is added to this Policy:

SCHEDULE OF BENEFITS FOR PEDIATRIC VISION CARE SERVICES

A Covered Person's vision care Benefits are highlighted below. To fully understand all the terms, conditions, limitations, and exclusions which apply to a Covered Person's Benefits, please read this entire Policy.

PEDIATRIC VISION CARE BENEFITS		
Vision Care Services	**In-Network Covered Person Cost**	**Out-of-Network Allowance[1]**
Exam (with dilation as necessary):	No Copayment	$30
Frames: (any available frame at Provider location)		
Provider Designated Frames	No Copayment	$75
Non-Provider Designated Frames	No Copayment up to $150 allowance - Covered Persons receive 20%[2] off balance over $150	$75
Standard Plastic, Glass, or Poly Spectacle Lenses:		
Single Vision	No Copayment	$25
Bifocal	No Copayment	$40
Trifocal	No Copayment	$55
Lenticular	No Copayment	$55
Standard Progressive Lens	No Copayment	$55
Lens Options:		
Ultraviolet Treatment	No Copayment	$12
Tint (Solid and Gradient)	No Copayment	$12
Standard Plastic Scratch Coating	No Copayment	$12
Standard Polycarbonate	No Copayment	$32
Glass	No Copayment	Not Covered
Photochromic / Transitions Plastic	No Copayment	$57
Contact Lenses: (Contact lens allowance includes materials only)		
Conventional	No Copayment up to $150 allowance - Covered Persons receive 15%[2] off balance over $150	$150
Disposable	No Copayment up to $150 allowance	$150
Medically Necessary	No Copayment	$210

[1] *The Plan pays the lesser of the maximum allowance noted or the retail cost. Retail prices vary by location.*
[2] *Additional discounts are not applicable at certain retail outlets. Call a Customer Service Representative or visit www.eyemed.com for additional information. Discounts are not insurance and are subject to change at anytime without notice.*

PEDIATRIC VISION CARE BENEFITS		
Pediatric Vision Care Services	**In-Network Covered Person Cost**	**Out-of-Network Allowance[1]**
Note: Additional Benefits over allowance are available from Network Providers except certain retail outlets. Call a Customer Service Representative or visit www.eyemed.com for additional information.		
Routine eye exams do not include professional services for contact lens evaluations. Any applicable fees are the responsibility of the Covered Person.		
Frequency:		
Examination	Once every Benefit Period	
Lenses or Contact Lenses	Once every Benefit Period	
Frames	Once every Benefit Period	
Additional Benefits		
Medically Necessary contact lenses: Contact lenses may be determined to be Medically Necessary and appropriate in the treatment of Covered Persons 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.		
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. Covered low vision services (both In- and Out-of-Network) will include one comprehensive low vision evaluation every 5 years; high-power spectacles, magnifiers and telescopes; and follow-up care – four visits in any five-year period.		

D. EXCLUSIONS

In addition to the ***Exclusions and Limitations*** listed in the Policy, services or materials connected with or charges arising from the following are not covered:

- 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;
- office infection control charges;
- charges for copies of Covered Persons' records, charts, or any costs associated with forwarding/mailing copies of Covered Persons' records or charts;
- state or territorial taxes on vision services performed;
- medical and/or surgical treatment of the eye, eyes or supporting structures;
- orthoptic or vision training; aniseikonic spectacle lenses;

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

- any eye or vision examination, or any corrective eyewear required for a Covered Person as a condition of employment; safety eyewear;
- non-prescription sunglasses;
- services rendered after the date a Covered Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Covered Person are within 31 days from the date of such order;
- services or materials provided by any other group benefit plan providing vision care;
- special lens designs or coatings other than those described in this Policy;
- lost or broken lenses, frames, glasses or contact lenses will not be replaced except in the next Benefit frequency when Vision Materials would next become available;
- non-prescription (Plano) lenses and/or contact 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 Covered Persons receive from immediate relatives or household members, such as a spouse, parent, child, brother or sister, by blood, marriage or adoption;
- services covered under medical Benefits.

E. HOW THESE PEDIATRIC VISION CARE BENEFITS WORK

Under this coverage, a Covered Person may visit any Vision Care Network Provider and receive Benefits for a vision examination. In order to maximize Benefits for most covered Vision Materials, however, the Covered Person must purchase them from a Vision Care Network Provider.

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 Covered Persons obtain eyeglasses or contacts from an Out-of-Network Provider, they must pay the Provider in full and submit a claim for reimbursement (see ***Claim Provisions*** for more information).

A Covered Person may receive their 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 their 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 section, must be paid in full by the Covered Person to the Provider, whether or not the Provider participates in the vision care network.

Benefits under this section may not be combined with any discount or promotional offering. Allowances are one-time use Benefits; no remaining balances are carried over to be used later.

For information regarding a Covered Person's right to appeal a claim determination, refer to ***Complaint/Appeal Procedure***.

Except as amended by this section, all other terms, conditions, limitations and exclusions of the Policy, to which this Addendum is attached, will remain in full force and effect.

Claim Provisions

This Policy begins to provide Benefits only after any applicable Copayment and/or Deductible amount a Covered Person incurs toward eligible expenses shows on our records. When a Covered Person's Physician, Hospital, or other Provider of health care services submits bills for a Covered Person, the Covered Person's Copayment and/or Deductible will be recorded automatically and then the Covered Person's program will begin its share of the payment. If a Covered Person files their own claims, they must submit copies of all their bills, even those they must pay to meet their Copayment and/or Deductible. Then our records will show that they have incurred the Copayment and/or Deductible amount, and their health care coverage will begin to help pay the balance of their eligible expenses.

PARTICIPATING PROVIDERS

Participating Providers, even those outside a Covered Person's network, have agreed to submit claims directly to the Plan for a Covered Person. Simply show the Covered Person's Identification Card and claims submission will be handled for them. If a Covered Person uses an Out-of-Network Provider who does not file for them, they should follow the guidelines below in submitting their claims.

REMEMBER...

To receive the maximum Benefits under this Policy for Covered Services, a Covered Person must receive treatment from Network Providers.

PRESCRIPTION DRUG CLAIMS

To be eligible for maximum Benefits and automatic claims filing, always use Participating Pharmacies.

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

HOSPITAL CLAIMS

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

AMBULATORY SURGICAL FACILITY AND OTHER FACILITY CLAIMS

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

PHYSICIAN AND OTHER PROVIDER CLAIMS

If a Covered Person is treated by a Physician or other Provider who does not have an agreement with us, the Covered Person ordinarily has to pay the bill and then file the claim themself, along with an itemized statement from their Physician or other Provider. The Covered Person will then be paid directly for

Covered Services after we subtract any Deductible, Copayment and/or Coinsurance amounts which apply to their coverage.

STUDENT-FILED CLAIMS

When a Covered Person must file a claim them self, they may obtain claim forms by contacting the Plan. They should be sure to fill out the claim form completely, sign it, and attach the Provider's or Pharmacy's itemized statement or receipt. Send the completed form to:

Medical Claims:

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

Outpatient Prescription Drug claims:

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

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

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

IMPORTANT: Remember to send the itemized statement with all the Covered Person's claims. It gives the following necessary information.

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

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

When a Covered Person files claims, they should be sure to keep copies of all bills and receipts for their own personal records.

Remember, we must receive a Covered Person's claims for Covered Services within 180 days following the end of the Benefit Period for which the claim is made.

BENEFIT DETERMINATIONS FOR PROPERLY FILED CLAIMS

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

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

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

The procedure for appealing an adverse Benefit determination is set forth below, under ***Complaint/Appeal Procedure***.

DIRECT CLAIMS LINE

A Covered Person may call a Customer Service Representative at the number shown on their Identification Card between 8:00 a.m. and 6:00 p.m., Monday through Friday, whenever they have a question concerning a claim or their membership.

Complaint/Appeal Procedure

The Plan has established the following process to review Covered Persons' dissatisfactions, complaints, and/or appeals. Covered Persons may designate an authorized representative, to act on their behalf in the appeal process.

If Covered Persons 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 the Covered Person with a satisfactory solution to their problem. However, if a resolution cannot be reached in an informal exchange, the Covered Person may request an administrative review of the problem through the Plan's appeal process described below.

The Covered Person 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 Policy to interpret and determine Benefits in accordance with the Policy provisions.

Covered Persons 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 Covered Persons' Benefits made by the Plan under this Policy.

IF A CLAIM IS DENIED OR NOT PAID IN FULL

On occasion, the Plan may deny all or part of a Covered Person's claim. There are a number of reasons why this may happen. The Plan suggests that a Covered Person first reads the Explanation of Benefits summary prepared by the Plan; then reviews this Policy to see whether they understand the reason for the determination. If the Covered Person has additional information that they believe could change the decision, they should send it to the Plan and request a review of the decision as described in *"Claim Appeal Procedures"* below.

If the claim is denied in whole or in part, the Covered Person will receive a written notice from the Plan 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 or administrative basis or protocol for the determination;
- A description of additional information which may be necessary to perfect the claim 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 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, Investigational and/or Unproven treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;
- In the case of a denial of an Urgent Care Claim, a description of the expedited review procedure applicable to such claims. An Urgent Care Claim decision may be provided orally, so long as a written notice is furnished to the claimant within three days of oral notification; and
- Contact information for applicable office of health insurance consumer assistance or ombudsman.

TIMING OF REQUIRED NOTICES AND EXTENSIONS

Separate schedules apply to the timing of required notices and extensions, depending on the type of claim. Claim refers to a request for 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 the Policy, for Benefits for Medical Care or treatment with respect to which the application of regular time periods for making health claim decisions could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment.
- **"Pre-Service Claim"** is any non-urgent request for Benefits or a determination with respect to which the terms of the Benefit plan condition receipt of the Benefit on approval of the Benefit in advance of obtaining Medical Care.
- **"Post-Service Claim"** (also known as "claim") is any request for a Benefit that is not a "pre-service" claim, and whereby notification that a service has been rendered or furnished to a Covered Person is submitted to the Plan in an acceptable form. This notification must include full details of the service received, including the Covered Person's 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 the Covered Person.

URGENT CARE CLAIMS*

Type of Notice or Extension	Timing
If the Covered Person's claim is incomplete, we must notify the Covered Person within:	**24 hours**
If the Covered Person is notified that their claim is incomplete, they must then provide completed claim information to the Plan within:	**48 hours after receiving notice**
If the Plan denies the Covered Person's initial claim, the Plan must notify the Covered Person 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**

*The Covered Person does not need to submit Urgent Care Claims in writing. They should call the Plan at the toll-free number listed on the back of the Identification Card as soon as possible to submit an Urgent Care Claim.

PRE-SERVICE CLAIMS

Type of Notice or Extension	Timing
If the Covered Person's claim is filed improperly, the Plan must notify the Covered Person within:	**5 days**
If the Covered Person's claim is incomplete, the Plan must notify the Covered Person within:	**15 days**
If the Covered Person is notified that their claim is incomplete, they must then provide completed claim information to the Plan within:	**45 days after receiving notice**
If the Plan denies the Covered Person's initial claim, the Plan must notify the Covered Person 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 the Covered Person, 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 expects to render a decision.

POST-SERVICE CLAIMS

Type of Notice or Extension	Timing
If the Covered Person's claim is incomplete, we must notify the Covered Person within:	**30 days**
If the Covered Person is notified that their claim is incomplete, they must then provide completed claim information to the Plan within:	**45 days after receiving notice**
The Plan must notify the Covered Person of any adverse claim determination:	
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 is necessary due to matters beyond the control of the Plan and (2) notifies the Covered Person 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 and/or Unproven or not Medically Necessary or appropriate. If an ongoing course of treatment had been approved by the Plan and the Plan reduces or terminates such treatment (other than by amendment or termination of this Policy) 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 cancellation of coverage that has a retroactive effect due to a failure to pay timely premiums towards coverage or attributable to routine changes, such as eligibility updates.

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

  Upon receipt of an expedited pre-service or concurrent clinical appeal, the Plan will notify the party filing the appeal, as soon as possible, but no more than 24 hours after submission of the appeal, of all information needed to review the appeal. Additional information must be submitted within 48 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***

  A Covered Person has the right to seek and obtain a full and fair review of any determination of a claim, any determination of a request for Preauthorization, or any other determination made by the Plan in accordance with the Benefits and procedures detailed in the Policy.

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

  If the Covered Person believes the Plan incorrectly denied all or part of their Benefits, they may have their claim reviewed. The Plan will review the decision in accordance with the following procedures:

  – Within 180 days after the Covered Person receives notice of an Adverse Benefit Determination, they may call or write to the Plan's Administrative Office. The Plan will need to know the reasons why the Covered Person does not agree with the Adverse Benefit Determination. Send the request to:

    Appeal Coordinator – Customer Service Department

    Blue Cross and Blue Shield of Oklahoma

    P.O. Box 3283

    Tulsa, OK 74102-3283

  – The Plan will honor telephone requests for information. However, such inquiries will not constitute a request for review.

  – In support of the Covered Person's claim review, the Covered Person has the option of presenting evidence and testimony to the Plan. The Covered Person and their authorized representative may ask to review the Covered Person's file and any relevant documents and may submit written issues, comments and additional medical information within 180 days after they receive notice of an Adverse Benefit Determination or at any time during the claim review process.

    The Plan will provide the Covered Person or their authorized representative with any new or additional evidence or rationale and any other information and documents used in the review of the Covered Person's 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 the Covered Person or their authorized representative sufficiently in advance of the date a final decision on appeal is made in order to give the Covered Person a chance to respond. Clinical appeal determinations may be made by a Physician associated or contracted with the Plan and/or by external advisors, but who were not involved in making the initial denial of the Covered Person's claim. Before the Covered Person or their authorized representative may bring any action to recover Benefits, the claimant must exhaust the appeal process and must raise all issues with respect to a claim and must file an appeal or appeals and the appeals must be finally decided by the Plan.

  – If the Covered Person has any questions about the claim's procedures or the review procedure, they may call our Administrative Office Customer Service Representative at the number shown on the Identification Card.

- ***Timing of Appeal Determinations***

  Upon receipt of a non–urgent pre–service appeal, the Plan 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 the Plan.

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

- ***Notice of Appeal Determination***

  The Plan will notify the party filing the appeal, the Covered Person, 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 to the Covered Person or their authorized representative will include:

  – A reason for the determination;
  – A reference to the Benefit provisions on which the determination is based, or the contractual or administrative basis 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 the Plan's 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 the Plan;
  – 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 the Covered Person receives an Adverse Benefit Determination, they may have a right to have the Plan's decision reviewed by independent health care professionals who have no association with the Plan **if the Plan's 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 the Covered Person receives notice of the internal appeal determination, unless the Covered Person's medical condition qualifies them for an expedited external review of the Plan's denial. For a standard external review, a decision will be made within **45 days** of receiving the Covered Person's request. If the Covered Person has a medical condition that would seriously jeopardize their life or health or would

jeopardize their ability to regain maximum function if treatment is delayed, they may be entitled to request an **expedited external review** of the Plan's denial before the Covered Person's internal review rights have been exhausted. If the Plan's 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, the Covered Person also may be entitled to file a request for external review of the Plan's denial.

A Covered Person or their 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. The Plan will also provide the forms to the Covered Person upon request.

Oklahoma Insurance Department

P.O. Box 53408

Oklahoma City, OK 73152-3408

1-800-522-0071 (Oklahoma only)

405-521-2991

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

For questions about the Covered Person's rights or for additional assistance, the Covered Person may contact the Oklahoma Consumer Assistance Program at:

Oklahoma Insurance Department

400 NE 50th Street

Oklahoma City, OK 73105

http://www.ok.gov/oid/Consumer/index.html

Telephone: 1-800-522-0071 or 405-521-2828

General Provisions

ENTIRE CONTRACT

The entire contract consists of the Policy (including any endorsements or amendments), the signed application of the Policyholder, the Student enrollment form, Benefit and premium notification documents, if any, and rate summary documents, if any. All statements contained in the application will be deemed representations and not warranties. No such statements will be used to void the insurance, reduce the Benefits, or be used in defense of a claim for loss incurred unless it is contained in a written application.

No agent has the authority to modify or waive any part of the Policy, or to extend the time for payment of premiums, or to waive any of the Plan's rights or requirements. No modifications of the Policy will be valid unless evidenced by an endorsement or amendment of the Policy, signed by one of the Plan's officers and delivered to the Policyholder.

POLICY EFFECTIVE DATE

The Policy begins on the Policy Effective Date at 12:01 AM, Standard Time at the address of the Policyholder.

POLICY TERMINATION

The Plan may terminate this Policy by giving 31 days written (authorized electronic or telephonic) notice to the Policyholder. Either the Plan or the Policyholder may terminate this Policy on any Premium Due Date by giving 31 day advance written (authorized electronic or telephonic) notice to the other. This Policy may be terminated at any time by mutual written or authorized electronic/telephonic consent of the Policyholder and the Plan.

This Policy terminates automatically on the earlier of:

- the Policy Termination Date shown in the Policy;
- the Premium Due Date if premiums are not paid when due;
- the Policy Effective Date of the renewal of this Policy if a Student decides to renew coverage under this Policy, and the Policy Effective Date of the renewal of this Policy becomes effective before this Policy terminates.

Termination takes effect at 12:00 AM, Standard Time at the address of the Policyholder on the date of termination.

PREMIUMS

The premiums for this Policy will be based on the rates currently in force, the plan and amount of insurance in effect.

CHANGES IN PREMIUM RATES

The Plan may change the premium rates from time to time with at least 60 days advanced written, or authorized electronic or telephonic notice. No change in rates will be made until 12 consecutive months after the Policy Effective Date. An increase in rates will not be made more often than once in a 12-month period. However, the Plan reserves the right to change rates at any time if any of the following events take place.

- The terms of the Policy change.
- A division, subsidiary, affiliated organization or eligible Class is added or deleted from the Policy.

- There is a change in the factors bearing on the risk assumed.
- Any federal or state law or regulation is amended to the extent it affects the Plan's Benefit obligation.

If an increase or decrease in rates takes place on a date that is not a Premium Due Date, a pro rata adjustment will apply from the date of the change to the next Premium Due Date.

PAYMENT OF PREMIUM

The first Premium is due on the Policy Effective Date.

If any premium is not paid when due, the Policy will be canceled as of the Premium Due Date, except as provided below, under *"Policy Grace Period"*.

POLICY GRACE PERIOD

A Policy Grace Period of 31 days will be granted for the payment of the required premiums. The Policy will remain in force during the Grace Period. If the required premiums are not paid during the Policy Grace Period, insurance will end upon the expiration of the Grace Period. The Policyholder will be liable to the Plan for any unpaid premium for the time the Policy was in force.

REINSTATEMENT

If this Policy terminates due to default in premium payment(s), the subsequent acceptance of such defaulted premium by the Plan or any duly authorized agents shall fully reinstate the Policy. For purposes of this section mere receipt and/or negotiation of a late premium payment does not constitute acceptance. Any reinstatement of the Policy shall not be deemed a waiver of either the requirement of timely premium payment or the right of termination for default in premium payment in the event of any future failure to make timely premium payments.

CURRENCY

All premiums for and claims payable pursuant to the Policy are payable only in the currency of the United States of America.

NOTICE AND PROPERLY FILED CLAIM

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

The Covered Person's Properly Filed Claim must be furnished to the Plan within 180 days after the end of Benefit Period for which the claim is made.

Failure to provide a Properly Filed Claim to the Plan within the time specified above will not reduce any Benefit if the Covered Person shows that the claim was given as soon as reasonably possible.

PAYMENT OF BENEFITS

A Student authorizes the Plan to make payments directly to Providers giving Covered Services for which the Plan provides Benefits under the Policy. The Plan also reserves the right to make payments directly to a Student.

A Student cannot assign their right to receive payment to anyone else, either before or after Covered Services are received.

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

Benefits under the Policy will be based upon the Allowable Charge (as the Plan determines) for Covered Services. A Network Provider will accept the Allowable Charge as payment in full, less any Deductible, Copayment and/or Coinsurance, and will make no additional charge to a Student for Covered Services.

However, if a Student receives Covered Services from an Out-of-Network Provider, they may be responsible for amounts which exceed the Allowable Charge, in addition to any Deductible, Copayment and/or Coinsurance amounts which may apply. This does not apply to non-emergency services provided by an Out-of-Network Provider during a visit to an In-Network facility. When Out-of-Network non-emergency services are received in an In-Network facility, the Covered Person will incur no greater out-of-pocket costs than would have been incurred if the services were provided by an In-Network Provider. For services provided by non-participating Provider, the nonparticipating Provider may not bill the Covered Person for the difference between payment by this Plan and the Provider charges plus In-Network Deductible, Coinsurance and/or Copayment.

OUT-OF-AREA SERVICES

Blue Cross and Blue Shield of Oklahoma, a division of Health Care Service Corporation, herein called "the Plan" has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Arrangements". These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association. Whenever a Covered Person accesses health care services outside of the Plan's Service area, the claims for these services may be processed through one of these Inter-Plan Arrangements, which includes the "BlueCard® Program" and may include negotiated arrangements available between the Plan and other Blue Cross and Blue Shield Licensees.

Typically, when accessing care outside Our Service Area, a Covered Person will receive it from one of two kinds of Providers. Most Providers ("Participating Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). Some Providers ("Non-Participating Providers") don't contract with the Host Blue. We explain how we pay both types of Providers below.

- **BlueCard® Program**

  Under the BlueCard® Program, when a Covered Person receives Covered Services within the geographic area served by a Host Blue, we will remain responsible for what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its Participating Providers.

  Whenever a Covered Person receives Covered Services outside the Plan's Service Area and the claim is processed through the BlueCard Program, the amount he/she pays for Covered Services is calculated based on the lower of:

  – The billed Covered Charges for a Covered Person's Covered Services, or
  – The negotiated price that the Host Blue makes available to the Plan.

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

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

- **Non-Participating Providers Outside the Plan's Service Area**
  - **Liability Calculation**

    In general, when Covered Services are provided outside of the Plan's service area by Non-Participating Providers, the amount a Covered Person pays for such services will be calculated using the methodology described in the Policy for Non-Participating Providers located inside the Plan's service area. A Covered Person may be responsible for the difference between the amount that the Non-Participating Provider bills and the payment the Plan will make for the Covered Services as set forth in this paragraph. Payments for out-of-network emergency services are governed by applicable federal and state law.
  - **Exceptions**

    In some exception cases, the Plan may, but is not required to, in its sole and absolute discretion, negotiate a payment with such Non-Participating Provider on an exception basis. If a negotiated payment is not available, then the Plan may make a payment based on the lesser of:
    - the amount calculated using the methodology described in the Policy for non-participating Providers located inside our service area (described above): or
    - the following:
      - for professional Providers, make a payment based on publicly available Provider reimbursement data for the same or similar professional services, adjusted for geographical differences where applicable; or
      - for Hospital or facility Providers, make a payment based on publicly available data reflecting the approximate costs that Hospitals or facilities have incurred historically to provide the same or similar service, adjusted or geographical differences where applicable, plus a margin factor for the Hospital or facility.

    In these situations, a Covered Person may be liable for the difference between the amount that the non-participating Provider bills and the payment Blue Cross and Blue Shield of Oklahoma will make for the Covered Services as set forth.

- **Blue Cross Blue Shield Global Core**

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

  If a Covered Person needs medical assistance services (including locating a Physician or Hospital) outside the BlueCard service area, they should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a Physician appointment or hospitalization, if necessary.
  - **Emergency Care Services**

    This Policy covers only limited health care services received outside of the United States. As used in this section, "Out-of-Area Services" include Emergency Services, Emergency Accident Care, Emergency Care, Emergency Medical Care and Urgent Care obtained outside the geographic area we serve. Follow-up care following an emergency is also available, provided the services are Preauthorized by the Plan. Any other services will not be eligible for Benefits unless authorized by the Plan.

- **Inpatient Services**

  In most cases, if the Covered Person contacts the service center for assistance, Hospitals will not require the Covered Person to pay for covered Inpatient services, except for their cost-share amounts/Deductibles, Coinsurance, etc. In such cases, the Hospital will submit the Covered Person's claims to the service center to begin claims processing. However, if the Covered Person paid in full at the time of service, they must submit a claim to receive reimbursement for Covered Services. **The Covered Person must contact the Plan to obtain Preauthorization for non-emergency Inpatient services.**

- **Outpatient Services**

  Outpatient services are only available for Emergency Care. Physicians, Urgent Care centers and other Outpatient Providers located outside the BlueCard service area will typically require a Covered Person to pay in full at the time of service. The Covered Person must submit a claim to obtain reimbursement for Covered Services.

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

  When a Covered Person pays for Covered Services outside the BlueCard service area, they must submit a claim to obtain reimbursement. For institutional and professional claims, a Covered Person should complete a Blue Cross Blue Shield Global Core International claim form and send the claim form with the Provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of the claim. The claim form is available from the Plan, the service center or online at *www.bcbsglobalcore.com*. If a Covered Person needs assistance with their claim submission, they should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, and seven days a week.

PHYSICAL EXAMINATION AND AUTOPSY

The Plan has the right to have a Physician of their choice examine the Covered Person as often as is reasonably necessary. This section applies when a claim is pending or while Benefits are being paid. The Plan also has the right to request an autopsy in the case of death, unless the law forbids it. Such examinations or autopsy will be at the expense of the Plan.

RIGHT OF RECOVERY

If the Plan makes payments with respect to Benefits payable under the Policy in excess of the amount necessary, the Plan has the right to recover such payments. The Plan will notify the Covered Person of such overpayment and request reimbursement from the Covered Person. However, if the Covered Person does not provide such reimbursement, the Plan will have the right to offset such overpayment against any other Benefits payable to the Covered Person under the Policy to the extent of the overpayment.

The Plan will not seek recovery of any excess or erroneous payment made under the Policy more than twenty-four (24) months after the payment is made unless:

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

PREMIUM REBATES AND PREMIUM ABATEMENTS; AND COST-SHARING

- **Rebate.** In the event federal or state law requires Blue Cross and Blue Shield of Oklahoma to rebate a portion of annual premiums paid, the Plan will provide any rebate as required or allowed by such federal or state law.
- **Abatement.** The Plan may from time to time determine to abate (all or some of) the premium due under this Policy for particular period(s).

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

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

- **Cost-sharing.** The Plan reserves the right from time to time to waive or reduce the Coinsurance, Copayments and/or Deductibles under this Policy.

EXAMINATION OF RECORDS AND AUDIT

The Plan shall be permitted to examine and audit the Policyholder's books and records at any time during the term of the Policy and within 2 years after final termination of the Policy as they relate to the premiums or subject matter of this insurance.

CLERICAL ERROR

A clerical error in record keeping will not void coverage otherwise validly in force, nor will it continue coverage otherwise validly terminated. Upon discovery of the error an equitable adjustment of premium shall be made.

LEGAL ACTIONS

No action at law or in equity may be brought to recover on the Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Policy. No such action may be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

MISSTATEMENT OF AGE

In the event the age of a Covered Person has been misstated, the premium rate for such person shall be determined according to the correct age as provided in this Policy and there shall be an equitable adjustment of premium rate made so that we will be paid the premium rate at the true age for the Covered Person.

CONFORMITY WITH STATE STATUTES

Any provision of the Policy which, on its Policy Effective Date, is in conflict with the statutes of the state in which it is delivered is hereby amended to conform to the minimum requirements of those statutes.

NOT IN LIEU OF WORKERS' COMPENSATION

This Policy is not a Workers' Compensation policy. It does not provide any Worker's Compensation benefit.

INFORMATION AND MEDICAL RECORDS

All claim information, including, but not limited to, medical records, will be kept confidential and except for reasonable and necessary business use, disclosure of such confidential claim information would not be performed without the authorization of the Covered Person or as otherwise required or permitted by applicable law.

COORDINATION OF BENEFITS

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

- **Definitions**

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

  "Other Contract" means any arrangement, providing health care benefits or services through:

  - Group, group-type, non-group, individual, blanket or franchise insurance coverage;
  - Blue Cross Plan, Blue Shield Plan, health maintenance organization and other prepayment coverage;
  - Coverage under labor-management trusteed plans, union welfare plans, employer organization plans or employee benefit organization plans;
  - Coverage toward the cost of which any employer has contributed, or with respect to which any employer has made payroll deduction;
  - Group or individual automobile insurance coverage; and
  - Coverage under any tax supported or government program, including Medicare, to the extent permitted by law.

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

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

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

- **Effect on Benefits**

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

  When we are primary, we will provide Benefits for Covered Services without regard to a Covered Person's coverage under any Other Contract.

  When we are secondary, the Benefits we provide for Covered Services may be reduced because of benefits received from the Other Contracts.

- **Order of Benefit Determination**

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

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

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

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

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

– When none of the above circumstances applies, the coverage a Covered Person has had for the longest time pays first, except that a contract which covers the Covered Person as a laid-off or retired employee or as a Dependent of such person pays after a contract which covers the Covered Person as other than a laid-off or retired employee or Dependent of such person.
– When the Plan requests information from another carrier to determine the extent or order of a Covered Person's benefits under an Other Contract, and such information is not furnished after a reasonable time, then the Plan shall:
  - Assume the Other Contract is required to determine its benefits first;
  - Assume the benefits of the Other Contract are identical to the Benefits of this Policy and pay its Benefits accordingly.

  Once the Plan receives the necessary information to determine the Covered Person's benefits under the Other Contract and to establish the order of benefit determination under the rules listed above, prior payments under this coverage will be adjusted accordingly (if the above rules require it).
– If the other carrier reduces the Covered Person's benefits because of payment they received under this coverage and the above rules do not allow such reduction, then the Plan will advance the remainder of its full Benefits under this coverage as if the Covered Person's Benefits had been determined in absence of an Other Contract. However, the Plan shall be subrogated to all of the Covered Person's rights under the Other Contract. The Covered Person must furnish all information reasonably required by the Plan in such event, and they must cooperate and assist the Plan in recovery of such sums from the other carrier.
– If the other carrier later provides benefits to a Covered Person for which the Plan has made payments or advances under this Coordination of Benefits provision, the Covered Person must hold all such payments in trust for the Plan and must pay such amount to the Plan upon receipt.

- **Facility of Payment**

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

- **Right of Recovery**

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

PLAN'S RIGHT OF RECOUPMENT

The Covered Person agrees to reimburse the Plan for Benefits the Plan has paid and for which the Covered Person was not eligible under the terms of the Policy. This payment is due and payable immediately when the Covered Person is notified by the Plan. Also, the Plan has the sole right to determine that any overpayments, wrong payments, or any excess payments made for the Covered Person under this Policy are an indebtedness which the Plan may recover. The Plan's acceptance of premiums or payment of Benefits under this Policy does not waive the Plan's rights to enforce these provisions in the future.

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

  If the Plan pays Benefits for eligible expenses incurred by the Student or their Dependents and it is found that the payment was more than it should have been, or was made in error ("Overpayment"),

Blue Cross Blue Shield of Oklahoma has the right to obtain a refund of the Overpayment from: (i) the person to, or for whom, such Benefits were paid, or (ii) any insurance company or plan, or (iii) any other persons, entities or organizations, including, but not limited to, Participating Providers or Out-of-Network Providers.

If no refund is received, the Plan (in its capacity as insurer or administrator) has the right to deduct any refund for any Overpayment due, up to an amount equal to the Overpayment, from:

- any future benefit payment made to any person or entity under this Policy, whether for the same or a different Covered Person; or,
- any future benefit payment made to any person or entity under a self-funded benefit program and/or Blue Cross Blue Shield of Oklahoma-administered insured benefit program administered by the Plan; or,
- any future benefit payment made to any person or entity under another group benefit plan or individual policy insured by the Plan; or,
- any future benefit payment, or other payment, made to any person or entity; or,
- any future payment owed to one or more Participating Providers or Out-of-Network Providers.

Further, the Plan has the right to reduce a Covered Persons' benefit plan's or policy's payment to a Provider by the amount necessary to recover another Blue Cross Blue Shield of Oklahoma plan's or policy's Overpayment to the same Provider and to remit the recovered amount to the other Blue Cross Blue Shield of Oklahoma plan or policy.

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

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

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

PROPRIETARY MATERIALS

The Policyholder acknowledges that the Plan has developed operating manuals, certain symbols, trademarks, service marks, designs, data, processes, plans, procedures and information, all of which are proprietary information ("Business Proprietary Information"). The Policyholder shall not use or disclose to any third-party Business Proprietary Information without the Plan's prior written consent. Neither party shall use the name, symbols, trademarks or service marks of the other party or the other party's respective clients in advertising or promotional materials without prior written consent of the other party; provided, however, that the Plan may include the Policyholder in its list of clients.

THE PLAN'S SEPARATE FINANCIAL ARRANGEMENTS WITH PRESCRIPTION DRUG PROVIDERS

The Plan hereby informs the Policyholder that it has contracts, either directly or indirectly, with Participating Prescription Drug Providers for the provision of, and payment for, Prescription Drug services to all persons entitled to Prescription Drug Benefits under individual certificates, group health insurance policies and contracts to which the Plan is a party, including this Policy, and that pursuant to the Plan's

contracts with Participating Prescription Drug Providers, under certain circumstances described therein, the Plan may receive discounts for Prescription Drugs dispensed to Covered Persons. Actual discounts used to calculate a Covered Person's share of the cost of Prescription Drugs will vary. Some discounts are currently based on industry-wide benchmark calculations which are determined by a third party and are subject to change.

The Policyholder understands that the Plan may receive such discounts. Neither the Policyholder nor Covered Persons hereunder are entitled to receive any portion of any such discounts. The drug fees/discounts that the Plan has negotiated with Prime Therapeutics LLC ("Prime") through the Pharmacy Benefit Management ("PBM") Agreement, will be used to calculate a Covered Person's share of the cost of Prescription Drugs for both retail and mail/Specialty Drugs. Except for mail/Specialty Drugs, the PBM Agreement requires that the fees/discounts that Prime has negotiated with Pharmacies (or other suppliers) are passed through to the Plan (and ultimately to the Covered Person as described above).

For the mail order Pharmacy and Specialty Pharmacy program owned by Prime, Prime retains the difference between its acquisition cost and the negotiated prices as its fee for the various administrative services provided as part of the mail Pharmacy and/or Specialty Pharmacy program. The Plan pays a fee to Prime for Pharmacy Benefit services. A portion of Prime's PBM fees are tied to certain performance standards, including, but not limited to, claims processing, customer service response, and mail-order processing.

The amounts received by Prime from the Plan, Pharmacies, manufacturers or other third parties may be revised from time to time. Some of the amounts received by Prime may be charged each time a claim is processed (or, in some instances, requested to be processed) through Prime and/or each time a prescription is filled, and include, but are not limited to, administrative fees charged by Prime to the Plan (as described above), administrative fees charged by Prime to Pharmacies, and administrative fees charged by Prime to pharmaceutical manufacturers. Currently, none of these fees will be passed on to a Covered Person as expenses, or accrue to the benefit of a Covered Person, unless otherwise specifically set forth in this Policy. Additional information about these types of fees or the amount of these fees is available upon request. The maximum that Prime will receive from any pharmaceutical manufacturer for certain administrative fees will be 3% of the total sales for all rebatable products of such manufacturer dispensed during any given Calendar Year to members of the Plan and other Blue Plan operating divisions.

THE PLAN'S SEPARATE FINANCIAL ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS

The Plan hereby informs the Policyholder and all Covered Persons that it owns a significant portion of the equity of Prime and that the Plan has entered into one or more agreements with Prime or other entities (collectively referred to as "Pharmacy Benefit Managers"), for the provision of, and payment for, Prescription Drug Benefits to all persons entitled to Prescription Drug Benefits under individual certificates, group health insurance policies and contracts to which the Plan is a party, including this Policy. Pharmacy Benefit Managers have agreements with pharmaceutical manufacturers to receive rebates for using their products. In addition, Prime's mail order Pharmacy and other PBM services operate through the same entity, Prime Therapeutics LLC.

Prime negotiates rebate contracts with pharmaceutical manufacturers on behalf of the Plan but does not retain any rebates (although Prime may retain any interest or late fees earned on rebates received from manufacturers to cover the administrative costs of processing late payments). The Plan may receive such rebates from Prime. Neither the Policyholder nor Covered Persons hereunder are entitled to receive any portion of any such rebates as they are calculated into the pricing of the product.

SEVERABILITY

In case any one or more of the provisions contained in this Policy shall, for any reason, be held to be invalid, illegal or unenforceable in any respect, such invalidity, illegality or unenforceability shall not affect any other provisions of this Policy and the Policy shall be construed as if such invalid, illegal or unenforceable provision had never been contained herein.

NOTICE OF ANNUAL MEETING

The Policyholder is hereby notified that it is a Member of Health Care Service Corporation, a Mutual Legal Reserve Company, and is entitled to vote either in person, by its designated representative or by proxy at all meetings of Members of the Plan. The annual meeting is held at its principal office at 300 East Randolph Street, Chicago, Illinois each year on the last Tuesday in October at 12:30 p.m. For purposes of the aforementioned paragraph the term "Member" means the group, trust, association or other entity to which this Policy has been issued. It does not include Covered Persons under the Policy. Further, for purposes of determining the number of votes to which the Policyholder may be entitled, any reference in the Policy to "premium(s)" shall mean "charge(s)".

SERVICE MARK REGULATION

On behalf of the Policyholder and its Covered Persons, the Policyholder hereby expressly acknowledges its understanding that the Policy constitutes a contract solely between the Policyholder and the Plan. The Plan is an independent corporation operating under a license with the Blue Cross and Blue Shield Association (the "Association"), an association of independent Blue Cross and Blue Shield Plans. The Association permits us to use the Blue Cross and Blue Shield Service Mark in our service area and we are not contracting as the agent of the Association. The Policyholder further acknowledges and agrees that it has not entered into the Policy based upon representations by any person other than persons authorized by us and that no person, entity or organization other than the Plan shall be held accountable or liable to the Policyholder for any of our obligations to the Policyholder created under the Policy. This paragraph shall not create any additional obligations whatsoever on our part, other than those created under other provisions of this Policy.

RESCISSION OF COVERAGE

Any act, practice or omission that constitutes fraud or making an intentional misrepresentation of a material fact with the intent to deceive the Plan on the Student's application, may result in the cancellation of the Student's coverage (and/or coverage of any Dependents), retroactive to the Policy Effective Date, subject to 30 days' prior notification. A rescission does not include other types of coverage cancellations, such as a cancellation of coverage due to a failure to pay timely premiums towards coverage or cancellations attributable to routine eligibility and enrollment updates. In the event of such rescission, the Plan may deduct from the premium refund any amounts made in claim payments during this period, and the Student may be liable for any claims payment amount greater than the total amount of premiums paid during the period for which rescission is affected. At any time when the Plan is entitled to rescind coverage already in force, or is otherwise permitted to make retroactive changes to this Policy, the Plan may at its option make an offer to reform the Policy already in force or is otherwise permitted to make retroactive changes to this Policy and/or change in the rating category/level. In the event of reformation, the Policy will be reissued retroactive in the form it would have been issued had the misstated or omitted information been known at the time of application. Please refer to ***Complaint/Appeal Procedure*** for appeal rights concerning rescission and/or reformation.

ELIGIBLE ORGANIZATION ACCOMMODATION

A certificate(s) may have been provided to the Plan that this Student health plan is established or maintained by an organization(s) that is an "eligible organization(s)" as defined in 45 C.F.R. 147.131(b), as modified or replaced, and qualifies for an eligible organization accommodation with respect to the Affordable Care Act requirement to cover certain contraceptive services without cost sharing under guidelines supported by the Health Resources and Services Administration ("Eligible Organization Accommodation"). Provided that the Eligible Organization Accommodation is satisfied, coverage under this Student health plan will not include coverage for some or all of such contraceptive services. Students can call Customer Service at the number on the back of their ID card for more information. If Students have questions regarding the certification(s), they may contact their Institution. For other questions about the Eligible Organization Accommodation, Students may contact Customer Service at the number on the back of their ID card.

IDENTITY THEFT PROTECTION

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

Definitions

Throughout this Policy, many words are used which have a specific meaning when applied to a Covered Person's health care coverage. These terms will always begin with a capital letter. When a Covered Person comes across these terms while reading this Policy, he/she can refer to these *Definitions* because they will help them understand some of the limitations or special conditions that may apply to his/her Benefits. If a term within a definition begins with a capital letter, that means that the term is also defined in these *Definitions*. All definitions have been arranged in ALPHABETICAL ORDER. In this Policy we refer to Blue Cross and Blue Shield of Oklahoma as "the Plan" and we refer to the Institution of higher education in which a Student is enrolled and active as the "Institution."

ACCIDENT

A sudden, unexpected and unintended identifiable event producing at the time objective symptoms of an Injury. The Accident must occur while the Covered Person is insured under the Policy.

ALLOWABLE CHARGE

The charge that the Plan will use as the basis for Benefit determination for Covered Services a Covered Person receives under the Policy. The Plan will use the following criteria to establish the Allowable Charge:

- ***For Accident and Sickness Medical Expense Benefits:***
  - **Network Providers** – the Provider's usual charge, not to exceed the amount the Provider has agreed to accept as payment for Covered Services in accordance with a Network Provider agreement.
  - **Out-of-Network (Non-Contracting) Providers** – the lesser of: (a) the Provider's billed charge; or (b) the Plan's Non-Contracting Allowable Charge as set forth in ***Important Information***.
- ***For Outpatient Prescription Drug Benefits:***
  - **Participating Pharmacies** – the Pharmacy's usual charge, not to exceed the amount the Pharmacy has agreed to accept as payment for Covered Services in accordance with a Participating Pharmacy agreement.
  - **Out-of-Network Pharmacies** – the Pharmacy's usual charge, up to the amount that the Plan would reimburse a Participating Pharmacy for the same service.

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

AMBULATORY SURGICAL FACILITY

A Provider with an organized staff of Physicians which:

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

BENEFIT PERIOD

The period of time starting with the Policy Effective Date through the Termination Date as shown on the face page of the Policy. The Benefit Period is as agreed to by the Policyholder and the Plan.

BENEFITS

The payment, reimbursement and indemnification of any kind which Covered Persons will receive from and through the Plan under this Policy.

BLUECARD PROVIDER

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

BRAND NAME DRUG

A drug or product manufactured by a single manufacturer as defined by a nationally recognized Provider of drug product database information. There may be some cases where two manufacturers will produce the same product under one license, known as a co-licensed product, which would also be considered as a Brand Name Drug. There may also be situations where a drug's classification changes from Generic to Preferred or Non-Preferred Brand Name due to a change in the market resulting in the Generic Drug being a single source, or the drug product database information changing, which would also result in a corresponding change to a Covered Person's payment obligations from Generic to Preferred or Non-Preferred Brand Name.

CALENDAR YEAR

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

CERTAIN DIAGNOSTIC PROCEDURES

- Bone Scan
- Cardiac Stress Test
- CT Scan (with or without contrast)
- MRI (Magnetic Resonance Imaging)
- Myelogram
- PET Scan (Positron Emission Tomography)

COINSURANCE

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

COPAYMENT

A fixed dollar amount required to be paid by or on behalf of a Covered Person in connection with the delivery of some Covered Services.

COVERED ACCIDENT

An Accident that occurs while coverage is in force for a Covered Person and results in a loss or Injury covered by the Policy for which Benefits are payable.

COVERED DRUG

Any Prescription Drug which is included on the applicable Drug List, injectable drug, or self-injectable drug including insulin, disposable syringes, and disposable needed for self-administration.

COVERED EXPENSES

Expenses actually incurred by or on behalf of a Covered Person for treatment, services and supplies not excluded or limited by the Policy. Coverage under the Policy 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.

COVERED PERSON

Any eligible Student who applies for coverage, and for whom the required premium is paid to us.

COVERED SERVICE

A service or supply specified in this Policy for which Benefits will be provided.

CUSTODIAL CARE

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

DEDUCTIBLE

The dollar amount of Covered Expenses that must be incurred as an out-of-pocket expense by each Covered Person on a Policy Term basis before Benefits are payable under the Policy.

DRUG LIST

A list of drugs that may be covered under ***Outpatient Prescription Drugs and Related Services***. The Drug List is subject to periodic review and may be changed at any time by the Plan. A current list is available on our Web site at *www.bcbsok.com*. Covered Persons may also contact a Customer Service Representative at the number shown on the Identification Card for more information.

EFFECTIVE DATE OF COVERAGE

The date when a Covered Person's coverage begins under this Policy.

ELIGIBLE PERSON

A person entitled to apply as a Student under the Policy, as specified in ***Eligibility for Insurance***.

EMERGENCY CARE

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

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

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

EXPERIMENTAL/INVESTIGATIONAL/UNPROVEN

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

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

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

GENERIC DRUG

A drug that has the same active ingredient as a Brand Name Drug and is allowed to be produced after the Brand Name Drug's patent has expired. In determining the brand or generic classification for Prescription Drugs and corresponding payment level, the Plan utilizes the generic/brand status assigned by a nationally recognized Provider of drug product database information. A list of Generic Drugs is available by accessing the Web site at *www.bcbsok.com*. A Covered Person may also contact a Customer Service Representative at the number shown on the Identification Card for more information.

HOSPICE

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

HOSPITAL

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

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

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

HOSPITAL CONFINED

A stay as a registered bed-patient in a Hospital. If a Covered Person is admitted to and discharged from a Hospital within a 24-hour period but is confined as a bed-patient for the duration of the stay in the Hospital, the admission shall be considered a Hospital Confinement.

IDENTIFICATION CARD

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

IMMEDIATE FAMILY

A Covered Person's parent, spouse, child, brother or sister.

INJURY

Accidental bodily harm sustained by a Covered Person that results directly and independently from all other causes from a Covered Accident. 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.

INPATIENT

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

INSTITUTION

An institution of higher education as defined in the Higher Education Act of 1965.

INTERSCHOLASTIC ACTIVITIES

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.

LEGEND DRUGS

Drugs, biologicals, or compounded prescriptions which are required by law to have a label stating "Caution – Federal Law Prohibits Dispensing Without a Prescription" and which are approved by the U.S. Food and Drug Administration (FDA) for a Particular use or purpose.

LICENSED PRACTICAL OR VOCATIONAL NURSE (LPN OR LVN)

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

LIFE-THREATENING DISEASE OR CONDITION

For the purposes of a clinical trial, any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

MATERNITY SERVICES

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

MEDICAL CARE

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

MEDICALLY NECESSARY (OR MEDICAL NECESSITY)

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

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

MEDICARE

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

MENTAL ILLNESS

Any condition or disorder involving a mental health condition or substance use disorder listed under any of the diagnostic categories in the mental disorders section of the most recent edition of the International Classification of Disease or in the mental disorders section of the most recent version of the Diagnostic and Statistical Manual of Mental Disorders

NETWORK PHARMACY

An independent retail Pharmacy, chain of retail Pharmacies, mail-order Pharmacy or Specialty Pharmacy that has entered into a written agreement with the Plan, or other entity chosen by the Plan to administer its Prescription Drug program, to provide pharmaceutical services to Covered Persons at the time they receive the services. To find a Network Pharmacy, please refer to the Plan's Web site at www.bcbsok.com or call a Customer Service Representative at the number shown on the Identification Card.

NETWORK PROVIDER

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

NON-PREFERRED BRAND DRUG

A brand-name Prescription Drug which appears on the applicable Drug List and is identified as a Non-Preferred Brand Drug. The Drug List is available on the Plan's Web site at https://www.bcbsok.com/member/prescription-drug-plan-information/drug-lists.

NON-PREFERRED GENERIC DRUG

A Generic Drug which appears on the applicable Drug List and is identified as a Non-Preferred Generic Drug. The Drug List is available on the Plan's Web site at https://www.bcbsok.com/member/prescription-drug-plan-information/drug-lists.

NON-PREFERRED SPECIALTY DRUG

A Specialty Drug which appears on the applicable Drug List and is identified as a Non-Preferred Specialty Drug. The Drug List is available on the Plan's Web site at https://www.bcbsok.com/member/prescription-drug-plan-information/drug-lists.

OUT-OF-NETWORK PHARMACY

A Pharmacy that has not entered into a participating Pharmacy agreement with the Plan.

OUT-OF-NETWORK PROVIDER

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

OUT-OF-POCKET MAXIMUM

The total amount of Deductibles, Copayments and/or Coinsurance which must be satisfied during the Benefit Period for Covered Services received from Network Providers. Once the Out-of-Pocket Maximum has been reached, the amount of Allowable Charges covered by the Plan will increase to 100% during the remainder of the Benefit Period.

The Out-of-Pocket Maximum does not include services received from Out-of-Network Providers, amounts in excess of the Allowable Charge or charges for any services that are not covered under this Policy.

OUTPATIENT

A Covered Person receiving treatment while not an Inpatient. Services considered Outpatient, include, but are not limited to, services in an emergency room regardless of whether a Covered Person is subsequently registered as an Inpatient in a health care facility.

PHARMACY

A state and federally licensed establishment where the practice of Pharmacy occurs, that is physically separate and apart from any Provider's office, and where Legend Drugs and devices are dispensed under Prescription Orders to the general public by a pharmacist licensed to dispense such drugs and devices under the laws of the state in which he or she practices.

PHYSICIAN

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

PLACEMENT FOR ADOPTION (OR PLACED FOR ADOPTION)

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

PLAN

Blue Cross and Blue Shield of Oklahoma.

POLICY

This Policy issued by the Plan to the Institution, the Institution's Application for Student Blanket Health Insurance, the Covered Person's application(s) for coverage, as appropriate, along with any exhibits, appendices, addenda and/or other required information.

POLICY EFFECTIVE DATE

The date this Policy begins for the Policyholder, as shown on the face page of the Policy.

PREAUTHORIZATION

The process that determines in advance the Medical Necessity or Experimental, Investigational and/or Unproven nature of certain care and services under the Policy. Preauthorization does not guarantee that the care and services Covered Persons receive are eligible for Benefits under the Policy. At the time the Covered Person's claims are submitted, they will be reviewed in accordance with the terms of the Policy.

PREFERRED BRAND NAME DRUG

A brand-name drug which appears on the applicable Drug List and is identified as a Preferred Brand Drug. The Drug List is available on the Plan's Web site at https://www.bcbsok.com/member/prescription-drug-plan-information/drug-lists.

PREFERRED GENERIC DRUG

A Generic Drug which appears on the applicable Drug List and is identified as a Preferred Generic Drug. The Drug List is available on the Plan's Web site at https://www.bcbsok.com/member/prescription-drug-plan-information/drug-lists.

PREFERRED SPECIALTY DRUG

A Specialty Drug which appears on the applicable Drug List and is identified as a Preferred Specialty Drug. The Drug List is available on the Plan's Web site at https://www.bcbsok.com/member/prescription-drug-plan-information/drug-lists.

PREFERRED PARTICIPATING PHARMACY

A Participating Pharmacy which has a written Agreement with the Plan to provide pharmaceutical services to Subscribers or an entity chosen by the Plan to administer its Prescription Drug program that has been designated as a "Preferred Participating Pharmacy."

To find a Preferred Participating Pharmacy, please refer to the Plan's Web site at https://www.bcbsok.com/member/prescription-drug-plan-information/drug-lists or call a Customer Service Representative at the number shown on your Identification Card.

PREFERRED NETWORK PHARMACY

A Participating Pharmacy that has a written agreement with the Plan to provide pharmaceutical services to Covered Persons, or an entity chosen by the Plan to administer its Prescription Drug program, that has been designated as a Preferred Network Pharmacy.

PRESCRIPTION DRUGS

- prescription Legend Drugs;
- compound medications of which at least one ingredient is a prescription Legend Drug;
- prescription drugs that have been approved by the FDA for one protocol will be covered when found to be effective and prescribed for another;
- any other drugs that under the applicable state or federal law may be dispensed only upon written prescription of a Physician.

Prescription Drugs will also include FDA approved female contraceptive drugs and devices and Outpatient contraceptive services.

PRESCRIPTION ORDER

A written or verbal order from a Provider to a pharmacist for a drug to be dispensed. Orders written by a Provider located outside the United States to be dispensed in the United States are not covered under this Policy.

PREVENTIVE CARE SERVICES

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

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

PROPERLY FILED CLAIM

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

PROVIDER

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

PSYCHIATRIC HOSPITAL

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

"QUALIFYING INTERCOLLEGIATE SPORT"

A sport:

- which is not an Interscholastic Activity (as defined in this Policy); and
- which is administered by such Institution's department of intercollegiate athletics; and
- for which Benefits for Covered Accidents are provided for and payable under this Policy while Students are playing, participating, and/or traveling to or from an intercollegiate sport, contest or competition, including practice or conditioning for such activity.

REGISTERED NURSE (RN)

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

RESIDENTIAL TREATMENT CENTER

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

ROUTINE NURSERY CARE

Ordinary Hospital nursery care of the newborn Covered Person.

SICKNESS

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 Policy. All related conditions and recurrent symptoms of the same or similar condition will be considered one Sickness.

SKILLED NURSING FACILITY

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

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

SPECIALIST

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

SPECIALTY PHARMACY DRUGS

Prescription Drugs generally prescribed for use in limited patient populations or diseases. These drugs are typically injected but may also include drugs that are high cost oral medications and/or that have special storage requirements. In addition, patient support and/or education may be required for these drugs. The list of Specialty Drugs is subject to change. To determine which drugs are Preferred Specialty Drugs or Non-Preferred Specialty Drugs, a Covered Person should contact his/her Pharmacy, refer to the Drug List by accessing the Web site at *www.bcbsok.com* or contact Customer Service at the number listed on the back of the Identification Card.

SPECIALTY PHARMACY

A Participating Prescription Drug Provider that has a written agreement with the Plan or the entity chosen by the Plan to administer its Prescription Drug program to provide Specialty Drugs to Covered Persons.

STUDENT(S)

An individual Student or continued person who meets the eligibility requirements for this health coverage, as described in ***Eligibility of Insurance***.

SURGERY

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

THERAPY SERVICE

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

- **Chemotherapy** – the treatment of malignant disease by chemical or biological antineoplastic agents, but not including High-Dose Chemotherapy. High-Dose Chemotherapy is specifically addressed in certain sections under *"Human Organ, Tissue and Bone Marrow Transplant Services"*.

- **Occupational Therapy** – treatment of a physically disabled person by means of constructive activities designed and adapted to promote the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role.
- **Physical Therapy** – the treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles, and devices to relieve pain, to restore, attain or maintain maximum function, and to prevent disability or deterioration of a skill or function resulting from a disabling condition, disease, Injury, or loss of body part.
- **Radiation Therapy** – the treatment of disease by x-ray, radium, or radioactive isotopes.
- **Speech Therapy** – treatment for the correction of a speech impairment resulting from disease, Surgery, Injury, congenital and developmental anomalies, or previous therapeutic processes.

URGENT CARE

Treatment for an unexpected illness or Injury that is not an emergency, but which is severe or painful enough to require treatment within 24 hours. Examples include, but are not necessarily limited to: lacerations, high fever, severe vomiting and diarrhea, pulled muscles, or other similar illnesses or injuries.

VIRTUAL VISITS

Consultation with a licensed Provider through interactive video, or other communication technology allowed by applicable law, via online portal or mobile application.

BlueCross BlueShield of Oklahoma

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

NO SURPRISES ACT AMENDMENT

IT IS AGREED that the Policy to which this amendment is issued for attachment is amended as set forth below:

The terms of this Amendment supersede the terms of the Policy to which this Amendment is attached and becomes a part of the Policy. Unless otherwise required by Federal or Oklahoma law, in the event of a conflict between the terms on this Amendment and the terms of the Policy, the terms on this Amendment apply. However, definitions set forth in this Amendment are for purposes of this Amendment only. Additionally, for purposes of this Amendment, references to you and your mean any Student, including Dependents.

The Policy is hereby amended as indicated below:

I. Continuity of Care

If you are under the care of a participating Provider as defined in the Policy who stops participating in the Plan's network (for reasons other than failure to meet applicable quality standards, including medical incompetence or professional behavior, or fraud), you may be able to continue coverage for that Provider's Covered Services at the participating Provider Benefit level if one of the following conditions is met:

1. You are undergoing a course of treatment for a serious and complex condition,
2. You are undergoing institutional or inpatient care,
3. You are scheduled to undergo nonelective surgery from the Provider (including receipt of postoperative care from such Provider with respect to such surgery),
4. You are pregnant or undergoing a course of treatment for your pregnancy, or
5. You are determined to be terminally ill.

A serious and complex condition is one that (1) for an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm (for example, if you are currently receiving chemotherapy, radiation therapy, or post-operative visits for a serious acute disease or condition), and (2) for a chronic illness or condition, is (i) life-threatening, degenerative, disabling or potentially disabling, or congenital, and (ii) requires specialized medical care over a prolonged period of time.

Continuity coverage described in this provision shall continue until the treatment is complete but will not extend for more than 90 days beyond the date the Plan notifies you of the Provider's termination, or any longer period provided by state law. If you are in the second or third trimester of pregnancy when the Provider's termination takes effect, continuity of coverage may be extended through delivery of the child, immediate postpartum care, and the follow-up check-up within the first six (6) weeks of delivery. You have the right to appeal any decision made for a request for Benefits under this provision, as explained in the Policy.

II. Federal No Surprises Act

1. Definitions

The definitions below apply only to Section II. Federal No Surprises Act, of this Amendment. To the extent the same terms are defined in both the Policy and this Amendment, those terms will apply only to their use in thePolicy or this Amendment, respectively.

"Air Ambulance Services" means, for purposes of this Amendment only, medical transport by helicopter or airplane for patients.

"Emergency Medical Condition" means, for purposes of this Amendment only, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition: (i) placing the health of the individual, or with respect to a pregnant woman her unborn child in serious jeopardy; (ii) constituting a serious impairment to bodily functions; or (iii) constituting a serious dysfunction of any bodily organ or part.

"Emergency Services" means, for purposes of this Amendment only,

- a medical screening examination performed in the emergency department of a hospital or a freestanding emergency department;
- further medical examination or treatment you receive at a Hospital, regardless of the department of the Hospital, or a freestanding emergency department to evaluate and treat an emergency medical condition until your condition is stabilized; and
- Covered Services you receive from a non-participating provider during the same visit after your emergency medical condition has stabilized unless:
    1. Your Non-Participating Provider determines you can travel by non-medical or non-emergency transport;
    2. Your Non-Participating Provider has provided you with a notice to consent form for balance billing of services; and
    3. You have provided informed consent.

"Non-Participating Provider" means, for purposes of this Amendment only, with respect to a covered item or service, a Physician or other health care provider who does not have a contractual relationship with Blue Cross and Blue Shield of Oklahoma (BCBSOK) for furnishing such item or service under the Plan to which this Amendment is attached.

"Non-Participating Emergency Facility" means, for purposes of this Amendment only, with respect to a covered item or service, an emergency department of a hospital or an independent freestanding emergency department that does not have a contractual relationship with BCBSOK for furnishing such item or service under the Plan to which this Amendment is attached.

"Participating Provider" means, for purposes of this Amendment only, with respect to a Covered Service, a Physician or other health care provider who has a contractual relationship with BCBSOK setting a rate (above which the provider cannot bill the member) for furnishing such item or service under the Plan to which this Amendment is attached regardless whether the provider is considered a preferred or in-network provider for purposes of in-network or out-of-network Benefits under the subject Plan.

"Participating Facility" means, for purposes of this Amendment only, with respect to Covered Service, a Hospital or ambulatory surgical center that has a contractual relationship with BCBSOK setting a rate (above which the provider cannot bill the member) for furnishing such item or service under the Plan to which this Amendment is attached. Whether the provider is considered a preferred or in-network provider for purposes of in-network or out-of-network Benefits under the subject Plan.

"Qualifying Payment Amount" means, for purposes of this Amendment only, a median of contracted rates calculated pursuant to federal or state law, regulation and/or guidance.

"Recognized Amount" means, for purposes of this Amendment only, an amount determined pursuant a state law that provides a method for determining the total amount payable for the item or service (if applicable); or, if there is no state law that provides a method for determining the total amount payable for the item or service, the lesser of the Qualifying Payment Amount or billed charges.

2. Federal No Surprises Act Surprise Billing Protections

a. The federal No Surprises Act contains various protections relating to surprise medical bills on services performed by Non-Participating Providers and Non-Participating Emergency Facilities. The items and services included in these protections ("Included Services") are listed below.

- Emergency Services obtained from a Non-Participating Provider or Non-Participating Emergency Facility.
- Covered non-Emergency Services performed by a Non-Participating Provider at a Participating Facility (unless you give written consent and give up balance billing protections).
- Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider.

b. Claim Payments

For Included Services, the Plan will send an initial payment or notice of denial of payment directly to the Provider.

c. Cost-Sharing

For non-Emergency Services performed by Non-Participating Providers at a Participating Facility, and for Emergency Services provided by a Non-Participating Provider or Non-Participating Emergency Facility, the Recognized Amount is used to calculate your cost-share requirements, including Deductibles, Copayments, and Coinsurance.

For Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider, the amount used to calculate your cost-share requirements, including Deductibles, Copayments, and Coinsurance, will be the lesser of the Qualifying Payment Amount or billed charges.

For Included Services, these cost-share requirements will be counted toward your Participating Provider deductible and/or Out-of-Pocket Maximum, if any.

3. Prohibition of Balance Billing

You are protected from balance billing on Included Services as set forth below.

If you receive Emergency Services from a Non-Participating Provider or non-Participating Emergency Facility, the most the Non-Participating Provider or non-Participating Emergency Facility may bill you is your in-network cost-share. You cannot be balance billed for these Emergency Services unless you give written consent and give up your protections not to be balanced billed for services you receive after you are in a stable condition.

When you receive Covered Non-Emergency Services from a Non-Participating Provider at a Participating Facility, the most those Non-Participating Providers may bill you is your Plan's in-network cost-share requirements. When you receive emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services at a Participating Facility, Non-Participating Providers can't balance bill you and may not ask you to give up your protections not to be balance billed. If you get other services at Participating Facilities, Non-Participating Providers can't balance bill you unless you give written consent and give up your protections.

If your Plan includes Air Ambulance Services as a Covered Service, and such services are provided by a Non-Participating Provider, the most the Non-Participating Provider may bill you is your in-network cost-share. You cannot be balance billed for these Air Ambulance Services.

NOTE: The revisions to your Plan made by this Amendment are based upon the No Surprises Act, a federal law enacted in 2020 and effective for Plan Years beginning on or after January 1, 2022. To the extent federal regulations are adopted or additional guidance is issued by federal regulatory agencies that alter the terms of this Amendment, the regulations and any additional guidance will control over conflicting language in this Amendment.

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

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

[Signature]

[President of] Blue Cross and Blue Shield of Oklahoma

BlueCross BlueShield of Oklahoma

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html

BlueCross BlueShield of Oklahoma

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984.

Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
العربية Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員, 請撥電話 號碼 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવા કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાર્યક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કૉલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें ।.
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
Diné Navajo	T'áá ni, éí doodago ła'da bíká ánánílwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł dóó bína'ídíłkidígíí bee nił h odoonih. Ata'dahalne'ígíí bich'į' hodíílnih kwe'é 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سؤالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با شماره 855-710-6984 تماس حاصل نمایید.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کررہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.