IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF OKLAHOMA

CHRISTINA and JEFFREY TERRY, husband and wife, each individually and on behalf of their minor child, G. TERRY, and on behalf of all others similarly situated,	)
Plaintiffs,	)
v.	) Case No. CIV-18-415-C
HEALTH CARE SERVICE CORPORATION, a mutual legal reserve company, d/b/a BLUE CROSS AND BLUE SHIELD OF OKLAHOMA,	) **JURY TRIAL DEMANDED**) **ATTORNEY'S LIEN CLAIMED**
Defendant.	)

COMPLAINT

Plaintiffs Christina and Jeffrey Terry, on their own behalf and on behalf of their minor child, G. Terry, and on behalf of all others similarly situated, by and through their undersigned attorneys, the law firms of McIntyre Law, P.C., Edward L. White, PC, and Logan & Lowry, LLP, and for their Complaint and claims for relief against the Defendant, Health Care Service Corporation, a mutual legal reserve company, d/b/a Blue Cross and Blue Shield of Oklahoma ("BCBSOK"), allege and state as follows, to wit:

I. PARTIES, JURISDICTION, AND VENUE

1. Christina and Jeffrey Terry and their minor child reside in Greer County, Oklahoma and were, at all relevant times, insured by BCBSOK per an individual preferred provider organization ("PPO") health insurance contract - Blue Preferred Gold PPO 007,

Id. No. 927705055, Group No. OG2009 ("Contract"). *See* **Exhibit 1**. Plaintiffs' benefits arising under the Contract are further set forth in BCBSOK's Schedule of Benefits for Comprehensive Health Care Services ("SOB") and its Outline of Coverage ("OOC"). *See* **Exhibit 2** and **Exhibit 3**, respectively. The Oklahoma Insurance Department ("OID") approved the Contract per the System for Electronic Forms Filing ("SERFF") Tracking No. OKCP-128997524 and the SOB and OOC per SERFF Tracking No. OKCP-129296234. The Contract, SOB, and OOC may be referred to herein as the "Policy Documents."

2. BCBSOK is an Illinois Corporation authorized to conduct business in Oklahoma and maintaining offices both in Oklahoma City at 3817 Northwest Expressway, Suite 300, 73112 and in Tulsa at 7777 E. 42nd Place, 74145.

3. The Court has subject matter jurisdiction over this action pursuant to 28 U.S.C. § 1332(d), the class contains members of diverse citizenship from Defendant, and the amount in controversy exceeds $5 million.

4. The Court has personal jurisdiction over Defendant because Defendant is located in this District.

5. Venue is proper in this District pursuant to 28 U.S.C. § 1391(b)(2), since the cause of action arose in this District and the unlawful conduct of Defendant, out of which the cause of action arose, took place in this District.

II. BACKGROUND

6. Upon implementation of the Patient Protection and Affordable Care Act ("ACA"), individuals, including Plaintiffs, were required to enroll in an ACA compliant

health insurance plan or face penalties. Plaintiffs enrolled in a health care plan offered by BCBSOK as evidenced by the Contract.

7. On January 13, 2014, G. Terry was born at Great Plains Regional Medical Center in Elk City, Oklahoma ("Great Plains")—premature and without his lungs fully developed. He was quickly transferred into the intensive care unit ("ICU") at Great Plains.

8. G.'s condition continued to deteriorate until the morning of January 15, 2014, when his pediatrician, Dr. Paul Firth, determined it necessary for G. to receive care that only Children's Hospital at OU Medical Center in Oklahoma City, Oklahoma ("Children's") could provide.

9. Due to the fact that G.'s lung function was deteriorating with each passing moment and the doctor's evaluation of the risk that he would not survive the length of a ground ambulance transfer, G.'s doctor ordered necessary, time-critical, emergency air transfer to a hospital with neonatal intensive care availability, to wit: Children's.

10. In order to save G.'s life, Rocky Mountain Holdings, LLC ("RMH"), evacuated him by emergency air ambulance from Great Plains in Elk City to Children's, which was *the closest hospital that could provide the necessary care*.

11. RMH billed Plaintiffs $49,999.00 for the flight from Elk City to Children's in Oklahoma City.

12. On or about May 29, 2014, BCBSOK sent an Explanation of Benefits ("EOB") stating the amount Plaintiffs may owe for the emergency air ambulance services was zero dollars, leading Plaintiffs to believe they would owe zero dollars for the

emergency air ambulance services. *See* **Exhibit 4**. However, like most of BCBSOK's documents, this one was ambiguous later noting that "your claim has been denied."

13. On September 4, 2014, BCBSOK sent Plaintiffs another EOB stating that the total benefits approved by BCBSOK for the emergency air ambulance transfer amounted to $2,909.92 and informed Plaintiffs that they were responsible for the remaining $47,089.08 of the air ambulance bill because RMH was an out-of-network provider. *See* **Exhibit 5**.

14. On or about September 22, 2014, Plaintiffs verbally appealed BCBSOK's benefit determination and contacted BCBSOK by telephone inquiring as to why BCBSOK paid such a small amount of the air ambulance bill. A BCBSOK representative informed Plaintiffs that BCBSOK would review the claim.

15. On October 7, 2014, BCBSOK adjusted the claim and sent another EOB stating that the total benefits approved by BCBSOK for the emergency air ambulance transfer was $4,849.86, an amount only $1,939.94 greater than BCBSOK's original benefit determination. Simultaneously, BCBSOK informed Plaintiffs—parents of a premature child born with severely undeveloped lungs—that "[s]ince an out-of-network provider performed the services, you are responsible for additional charges." *See* **Exhibit 6**. No explanation was provided to Plaintiffs by BCBSOC in the EOB of why the amount was adjusted or how it decided how much to pay. But in a correspondence with the OID BCBSOK explained that a claim review resulted in a decision, for reasons not explained, to "pay at the network level…per the [unspecified] member benefits."

16. Consequently, BCBSOK paid only a fraction of the bill, $4,849.86, which resulted in RMH alleging that Plaintiffs owed a remaining balance of $45,149.14 ("Alleged Balance").

17. Plaintiffs, in an emergency situation with their newborn child's life on the line, were without the luxury of taking the time to identify any in-network air ambulances, if any such air ambulances existed. On information and belief, no in-network air ambulance was available in that location at that time.

18. Furthermore, while ordering the emergency air ambulance transfer, the coordinator inquired about Plaintiffs' insurance, and was informed that they were insured by BCBSOK. There was no mention of the fact that the air ambulance provider was out-of-network or that the air ambulance services would not be covered by BCBSOK.

19. In desperation, Plaintiffs sent a request for assistance to the Oklahoma Insurance Department ("OID") seeking assistance in having BCBSOK cover the air ambulance services:

> I don't believe I should have to pay fifty thousand dollars to the helicopter company when I have insurance that I am paying for that should cover the cost of life saving procedures such as this. The insurance company . . . should cover the helicopter ride cost. The point of having insurance is covering individuals in case of a catastrophic event happening such as this. If they aren't going to cover emergencies, then what is the point of having insurance?

20. On or about December 31, 2014, BCBSOK responded to the OID's inquiry regarding Plaintiffs' Request for Assistance reiterating that $4,849.86 was the total amount BCBSOK would cover and that Plaintiffs were responsible for the remaining $45,149.14 because RMH was an out-of-network provider; BCBSOK alleged that insureds are

responsible for the difference between the billed amount and the amount paid by BCBSOK when the provider is out-of-network.

21. Plaintiffs, as noted above or otherwise, timely and properly appealed BCBSOK's improper payment of their claim.

22. On December 30, 2017 (almost four years after the subject emergency service was provided), BCBSOK sent a letter to Plaintiffs regarding Plaintiffs' appeal of BCBSOK's benefit determination, stating that BCBSOK reconsidered G.'s claim for services provided by RMH and that it determined the claim had been processed correctly. *See* **Exhibit 7**.[1]

23. On April 4, 2018, BCBSOK again sent a letter to Plaintiff, Christina Terry, regarding Plaintiffs' benefit determination appeal stating:

> Enclosed are the copies of your appeal documents you requested. Also included are the benefit term(s) or rule(s) we used for our review. Please see the copy of our decision letter to learn more about other appeal rights you may have.

See **Exhibit 8**.

24. In contravention of the Contract, BCBSOK failed to explain the rationale behind its decision in any of its communications to Plaintiffs or the OID. *See* **Exhibit 1**, at pp. 58-59 and 63. It is unclear exactly which of Plaintiffs' many communications with BCBSOK it treated as the appeal, but Plaintiffs and their representatives had multiple communications with BCBSOK over the years since receiving the emergency services at

[1] The denial letter from BCBSOK suggests that requests from Plaintiffs' counsel for medical records prompted BCBSOK to tardily issue clear denial of Plaintiffs' appeal.

issue, and BCBSOK failed to issue the final denial of appeal to Plaintiffs until, at least, December of 2017.

25. Inexplicably, BCBSOK only "provided" Plaintiffs with the "benefit term(s) or rule(s) [BCBSOK] used for [BCBSOK's] review" less than three weeks ago from the date of this Complaint. Moreover, BCBSOK's reference to the "benefit term(s) or rule(s)" consisted of the **ENTIRE** Policy Documents, which consist of nearly one hundred pages. It is unreasonable to assume that the Plaintiffs, or any other insured, could read and understand all one hundred pages of the Policy Documents, much less pinpoint the specific "benefit term(s) or rule(s)" BCBSOK used in denying Plaintiffs' appeal.

26. RMH has sought payment of the alleged balance from Plaintiffs, and, on or about November 13, 2014, RMH submitted the matter to United Resource Systems, Inc., a collections agency. RMH sued Plaintiff on April 7, 2015 to recover its billed amount. Greer County Case No. CJ-2015-8. Judgment was entered against Plaintiffs on September 4, 2015. A garnishment affidavit was served on October 9, 2015, seeking a total of $57,714.53 from Plaintiffs.

27. While it was an absolute shock to Plaintiffs that their insurance provider would leave them holding the bag for $45,149.14 of a $49,999.00 emergency air ambulance bill, it is common practice for BCBSOK to shirk its contractual responsibility and leave its insured responsible for the bulk of financially crippling, emergency air ambulance bills. *See* **Exhibit 9** - *Air Ambulance Lawsuit Could Become Class Action*, KFOR (last updated July 14, 2015), http://kfor.com/2016/07/13/air-ambulance-lawsuit-could-become-class-action. *See* **Exhibit 10** - Editorial: *Health insurance company makes big profits by playing*

hardball, St. Louis Post-Dispatch (Mar. 15, 2018), http://www.stltoday.com/opinion/editorial/editorial-health-insurance-company-makes-big-profits-by-playing-hardball/article_265b6c91-75f7-5dbb-a8d2-6038e2cfffea.html.

28. Principally, the Contract states that "if a Network Provider bills you more than the Allowable Charge for Covered Services,[2] ***you are not responsible for the difference***." **Exhibit 1**, at p. 1. (Emphasis in original). In other words, BCBSOK is contractually obligated to indemnify and hold Plaintiffs harmless against any in-network provider amounts billed to Plaintiffs above BCBSOK benefits paid for emergency services.

29. BCBSOK represented, and continues to represent, the Contract to be an ACA-compliant health insurance plan.

30. The ACA, at 42 U.S.C. § 18022(b)(4)(E), states that a qualified health plan shall not be treated as providing coverage for essential health benefits unless the plan provides that:

> (i) **coverage for emergency department services will be provided without imposing** any requirement under the plan for prior authorization of services or **any limitation on coverage where the provider of services does not have a contractual relationship with the plan for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the plan**

31. Further, the OID states:

> **ACA compliant policies must cover emergency services received by an out-of-network provider as if they were in-network. . . .**" ACA compliant policies have maximum out-of-pocket limits and unlimited lifetime benefits which limits your liability or exposure (how much of the expenses you have

[2] Covered Services" include emergency care services. *See generally, Id.;* **Exhibit 2** and **Exhibit 3**.

> to pay yourself). However, out-of-network charges, **except in emergency situations**, are your responsibility and you may be balanced billed so you must read your policies very carefully and know that your provider is in network before using their services. *Id.* (Emphasis added).

See **Exhibit 11** - *Health Insurance Basics*, Oklahoma Insurance Department (February 25, 2015), https://www.ok.gov/oid/Consumers/Insurance_Basics/Health.html. (Emphasis added).

32. The OID's position makes sense considering that the Emergency Medical Treatment and Active Labor Act ("EMTALA"), 42 U.S.C. § 1395dd, requires that hospitals provide appropriate transfer for patients that it cannot treat to a facility where the patient's condition can be treated more effectively. As such, the emergency air ambulance transfer is a portion of the ongoing emergency medical care hospitals are **required to provide by law**.

33. BCBSOK apparently agrees with the OID's position and EMTALA concepts as the "Selecting A Provider" section of the Contract directs that "in case of an emergency, you should seek immediate care from the closest health care Provider." *See* **Exhibit 1**, at p. 2. The Contract defines "Provider" as "[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." *Id.* at p.73. Conspicuously, BCBSOK's foregoing directive contains no disclaimer or qualification informing Plaintiffs of the consequences if the closest emergency health care Provider happens to be out-of-network (*e.g.*, BCBSOK's refusal to cover emergency service charges in excess of BCBSOK's

nominal benefits which are billed to Plaintiff by out-of-network emergency care Providers).

34. Additionally, the Contract states that Ambulance Services are covered "to the ***closest facility*** that can provide Covered Services appropriate for your condition. If none, you are covered for trips to the closest such facility outside your local area." *See* **Exhibit 1**, at p. 29. (Emphasis in original).[3] Further, the "Ambulance Services" description in the Contract does not differentiate benefit levels between in-network and out-of-network providers.

35. Likewise, both the SOB and OOC expressly state that the level of benefits paid for emergency care services provided by in-network and out-of-network providers are precisely the same. **Exhibit 2**, at p. 3 ("emergency care services") or p. 4 ("ambulance services"); **Exhibit 3**, at pp. 3 or 4. Emergency care services are one of the only Covered Services that are covered at the same benefit level regardless of a provider's network status. *See generally, Id.*

36. In addition to the Policy Documents, upon information and belief, BCBSOK developed a **non-OID approved** "Summary of Benefits and Coverage" for Plaintiffs' health insurance policy ("Summary"). The Summary contains a section concerning emergency medical transportation which also expressly informs Plaintiffs that the level of benefits paid for such emergency care services provided by in-network and out-of-network

[3] In Plaintiffs' case, Children's in Oklahoma City, Oklahoma was the closest facility that could provide the emergency care reasonably deemed necessary for G.

providers are precisely the same. Further, the Summary unequivocally indicates that no limitations or exclusions apply to BCBSOK benefits provided for emergency medical transportation regardless of a provider's status.

37. In accordance with the foregoing, RMH's out-of-network emergency air ambulance transfer of G. was required to be covered under Plaintiffs' Policy Documents as if RMH was in-network. BCBSOK's refusal to provide such coverage is a breach of its contractual obligations owed to Plaintiffs.

38. To make matters worse, BCBSOK's OID-approved Policy Documents are completely devoid of any reference to "balance billing"[4] or air ambulance services. BCBSOK is well versed in the constant coverage issues (including insureds appeals of benefit denials) associated with emergency air ambulance providers charging exorbitant amounts for flights which BCBSOK refuses to cover. Despite BCBSOK's knowledge of these issues, the Policy Documents do not even mention the possibility of BCBSOK denying full coverage for out-of-network air ambulance provider bills.

39. Plaintiffs' insurance policy includes ambiguous, conflicting, and confusing terms. As such, the Policy Documents, Summary, the OID's position regarding emergency service coverage, the ACA, EMTALA, and BCBSOK's own May 29, 2014 EOB stating Plaintiffs owed zero dollars create a reasonable expectation that emergency air ambulance

[4] In the health care industry, balance billing "occurs when providers bill a patient for the difference between the amount they charge and the amount that a patient's insurance pays." https://www.healthinsurance.org/glossary/balance-billing/ (last visited April 21, 2018).

services would be covered in full (and the insured held harmless for any provider bills exceeding BCBSOK's paid benefits).

40. This reasonable expectation of coverage is further evidenced by Plaintiffs' written statement in the OID Request for Assistance (December 1, 2014) which states in relevant part:

> I don't believe that I should have to pay fifty thousand dollars to the helicopter company when I have insurance that I am paying for that should cover the cost of life saving procedures such as this. The insurance company, BCBS of Oklahoma, should cover the helicopter ride cost. The point of having insurance is covering individuals in case of a catastrophic event happening such as this. If they aren't going to cover emergencies, then what is the point of having insurance?

41. Surprisingly, BCBSOK ignored its own policy when recently informing Plaintiff of its appeal denial. In *Martin v. Health Care Service Corp.*, the Plaintiff sued BCBSOK for its failure to cover $35,702.05 of RMH's $42,604.56 bill resulting from an **October 4, 2014**, emergency air transfer. 2017 WL 3573829 (W.D. Okla. 2017). The following recites applicable findings in the Court's August 17, 2017, Memorandum Opinion and Order ("Order"):

> Nearly two years after Plaintiff's air transfer, RMH and BCBS entered into a new rate agreement and decided to apply the agreement retroactively to Plaintiff's bill, leaving the current balance at zero. . . . the Court views the outcome of Defendant's decision to apply the new rates retroactively as a **public benefit**. This is an outcome similar to bargains struck during settlement negotiations, but in this case, Plaintiff received the benefit of a zero-balance bill without participating in settlement negotiations.

Martin, 2017 WL 3573829 at **1-2. (Emphasis added). *See* **Exhibit 12**. The Order in *Martin* was issued **more than four months before** BCBSOK's December 30, 2017, letter to Plaintiffs stating BCBSOK reconsidered G.'s claim for services provided by RMH

in 2014 and it determined the claim had been processed correctly. BCBSOK's refusal to retroactively apply its RMH rate agreement to G.'s claim, effectively leaving Plaintiffs with a zero balance, evidences BCBSOK's inconsistent claim processing procedures and breach of its obligations owed to Plaintiffs (*i.e.*, covering out-of-network emergency services as if they were in-networks).

42. Emergency services should be covered as in-network, but alternatively, the Contract purports that out-of-pocket expenses are limited – even for out-of-network services. The SOB and OCC state that the out-of-pocket maximum for out-of-network services are $3,000 per Subscriber, or $9,000 for all covered family members combined for in-network services. The SOB and OCC state that the out-of-pocket limit for out-of-network services are $6,000 per Subscriber, or **$18,000** for all covered family members combined. **Exhibit 2**, at p. 2; **Exhibit 3**, at p. 3. Likewise, upon information and belief, the Summary states, "**Is there an out-of-pocket limit on my expenses?** Yes . . . Out-of-Network: $6,000 Individual/**$18,000** Family."

43. The Contract further states that "[o]nce the Out-of-Pocket Limit has been reached, the amount of Allowable Charges covered by the plan will increase to 100% during the remainder of the Benefit Period." **Exhibit 1**, at p. 72.

44. Even if Plaintiffs could be balance billed for RMH's air transfer, BCBSOK would be contractually obligated to cover, or indemnify Plaintiffs against, any amounts exceeding Plaintiffs' $18,000 out-of-pocket limit. BCBSOK neglected to address the Plaintiffs' out-of-pocket limit in any of the communications between the parties. BCBSOK's refusal to cover or indemnify Plaintiffs the portion of the $45,149.14 RMH

bill above the applicable out-of-pocket limit is a breach of its obligations arising under the Policy Documents and other legal duties owed to its insureds.

45. Also, in the alternative, BCBSOK's Policy Documents fail to comply with the ACA's "greatest of 3 formula" relative to its coverage of out-of-network emergency services. Specifically, 42 U.S.C. § 18022(b)(4)(E) states that a qualified health plan shall not be treated as providing coverage for essential health benefits unless the plan provides that:

> (ii) if [emergency department services] are provided out-of-network, the cost-sharing requirement (expressed as a copayment amount or coinsurance rate) is the same requirement that would apply if such services were provided in-network[.]
>
> (Explanatory parenthetical added).

46. Similarly, 45 C.F.R. § 147.138(b)(3) states:

> A group health plan or health insurance issuer complies with the requirements of this paragraph (b)(3) if it provides benefits with respect to an emergency service in an amount at least equal to the greatest of the three amounts specified in paragraphs (b)(3)(i)(A),(B), and (C) of this section (which are adjusted for **in-network** cost-sharing requirements).
>
> **(A)** The amount negotiated with **in-network** providers for the emergency service furnished, excluding any in-network copayment or coinsurance imposed with respect to the participant, beneficiary, or enrollee. If there is more than one amount negotiated with **in-network** providers for the emergency service, the amount described under this paragraph (b)(3)(i)(A) is the median of these amounts, excluding any **in-network** copayment or coinsurance imposed with respect to the participant, beneficiary, or enrollee....
>
> **(B)** The amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable amount), excluding any **in-network** copayment or coinsurance imposed with respect to the participant, beneficiary, or enrollee. The amount in this paragraph (b)(3)(i)(B) is

determined without reduction for out-of-network cost sharing that generally applies under the plan or health insurance coverage with respect to out-of-network services. Thus, for example, if a plan generally pays 70 percent of the usual, customary, and reasonable amount for out-of-network services, the amount in this paragraph (b)(3)(i)(B) for an emergency service is the total (that is, 100 percent) of the usual, customary, and reasonable amount for the service, not reduced by the 30 percent coinsurance that would generally apply to out-of-network services (but reduced by the **in-network** copayment or coinsurance that the individual would be responsible for if the emergency service had been provided **in-network**).

(C) The amount that would be paid under Medicare (part A or part B of title XVIII of the Social Security Act, 42 U.S.C. 1395*et seq.*) for the emergency service, excluding any **in-network** copayment or coinsurance imposed with respect to the participant, beneficiary, or enrollee.

(Emphasis added).

47. In contravention of the ACA, the Contract contains the following:

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

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

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

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

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

Exhibit 1, at p. 8. BCBSOK's use of "contracting Provider" and "contracting cost-sharing provisions" differs from the ACA's requirements for calculating the allowable charge for emergency services rendered by out-of-network providers, which contains no reference to "contracting" providers. *See* 45 C.F.R. § 147.138(b)(3).

48. Under the Contract, it appears that a "contracting Provider" is a provider class different from "Network Providers" and BCBSOK's benefit obligations are likewise different for "contracting Providers" and "Network Providers." *Id.* at p. 1. Thus, the coverage provisions for out-of-network emergency services are improperly more restrictive than coverage provisions for the same services provided in-network in violation of the ACA.

49. Upon information and belief, if BCBSOK has negotiated a rate with network or contracting air ambulance providers that is greater than amounts identified in 45 C.F.R. § 147.138(b)(3)(B) & (C) and/or (2) & (3) set forth in paragraph 46 hereinabove, then BCBSOK failed to apply the median amount negotiated with said providers to Plaintiffs' air ambulance bill as required by the Contract and/or the ACA. *See generally*, **Exhibit 12**.

III. CLAIMS FOR RELIEF

COUNT I: BREACH OF CONTRACT AGAINST BCBSOK

50. Plaintiffs incorporate the allegations outside of this cause of action as if set forth in Count I in full.

51. BCBSOK and Plaintiffs were parties to the Policy Documents on the date of G.'s RMH emergency air transfer to Children's that is the subject of this lawsuit.

52. The Policy Documents, along with the Summary, the EOB dated May 29, 2014, the OID's position regarding coverage of in-network and out-of-network emergency services, the ACA, and EMTALA, created, and/or reinforced, Plaintiffs' reasonable expectation that RMH's emergency air transfer would be covered in the same fashion as if the air transfer was an in-network emergency services.

53. BCBSOK materially breached its contractual obligations owed to Plaintiffs by refusing to the cover RMH's emergency air transfer as if it was an in-network emergency service.

54. BCBSOK materially breached its contractual obligations owed to Plaintiffs by BCBSOK failing to issue the final denial of appeal to Plaintiffs until, at least, December of 2017.

55. BCBSOK further materially breached its contractual obligations owed to Plaintiffs by refusing to follow its past practice of retroactively applying its new rate agreement with RMH to Plaintiffs' RMH bill, which would have effectively left Plaintiffs with a zero balance. *See* **Exhibit 12**.

56. Additionally, and in the alternative, BCBSOK materially breached the Policy Documents by refusing to apply Plaintiffs' out-of-pocket individual or family limits of $3,000 and $9,000, respectively, if emergency services are treated properly as in-network, or in the alternative $6,000 and $18,000, respectively, to RMH's charges for the subject emergency air transfer and by further refusing to cover, or indemnify Plaintiffs against, any amounts exceeding said limit.

57. Additionally, and in the alternative, BCSOK materially breached the Policy Documents by: (i) misrepresenting the Contract as ACA-compliant; and (ii) failing to utilize the appropriate "greatest of three" formula mandated under the ACA when processing Plaintiffs' claim for benefits pertaining to RMH's emergency air transfer of G. to Children's.

58. As a direct and proximate result of BCBSOK's breach of contract, Plaintiffs have suffered harm for which they are entitled to recover damages in the amount of the Alleged Balance of $45,149.14 plus attorney's fees, costs incurred, and additional damages arising by virtue of collections actions and litigation initiated by RMH.

COUNT II: BAD FAITH AGAINST BCBSOK

59. Plaintiffs incorporate the allegations outside of this cause of action as if set forth in Count II in full.

60. RMH's out-of-network emergency air ambulance transfer of G. was required to be covered under Plaintiffs' Policy Documents as if RMH was in-network. BCBSOK's refusal to provide such coverage is a breach of its legal obligations owed to Plaintiffs requiring BCBSOK to deal fairly and in good faith with Plaintiffs.

61. At the very least, the Policy Documents and Summary include misleading, confusing, ambiguous, and conflicting terms regarding coverage for emergency services; however, Plaintiffs reasonably relied upon BCBSOK's assurance and expected that emergency services would be covered as in-network, and thus, Plaintiffs would not be financially responsible for amounts charged by RMH above BCBSOK's benefit payments.

BCBSOK's refusal to provide such coverage is a breach of its legal obligations owed to Plaintiffs requiring BCBSOK to deal fairly and in good faith with Plaintiffs.

62. Further, BCBSOK's refusal to cover Plaintiffs' claim as stated above was unreasonable, and in bad faith, under the circumstances because it did not perform a proper investigation of the claim. For example, BCBSOK did not timely investigate the claim as the very earliest denial of Plaintiffs' benefit appeal was issued to Plaintiffs on December 30, 2017, nearly four years after the air transfer.

63. Moreover, BCBSOK's refusal to cover Plaintiffs' claim as stated above was unreasonable, and in bad faith, under the circumstances because it did not evaluate the results of the investigation properly and had no reasonable basis for the refusal. For example, BCBSOK failed to follow its past practice of retroactively applying its new rate agreement with RMH to Plaintiffs' RMH bill, which would have effectively left Plaintiffs with a zero balance. *See* **Exhibit 12**.

64. BCBSOK's refusal to cover Plaintiffs' claim as stated above also was unreasonable, and in bad faith, under the circumstances because the amount BCBSOK offer to satisfy the claim ($4,849.86 of RMH's $49,999.00 total bill) was unreasonably low. This is especially true considering that BCBSOK is well versed in the constant coverage issues (including insureds appeals of benefit denials) associated with emergency air ambulance providers charging exorbitant amounts for flights which BCBSOK refuses to cover, and BCBSOK's past practice regarding retroactive application of its new rate agreement with RMH to other emergency air ambulance bills arising from 2014 air transfers. *See* **Exhibit 12**

65. Additionally, and in the alternative, the Policy Documents and Summary create a reasonable expectation of a limit on out-of-pocket expenses – even for out-of-network services. BCBSOK's refusal to cover RMH's emergency air transfer so as to cover, and indemnify Plaintiffs against, amounts billed above the limit for out-of-pocket expenses is a breach of its obligations owed to Plaintiffs requiring BCBSOK to deal fairly and in good faith with Plaintiffs.

66. Additionally, and in the alternative, BCBSOK acted in bad faith toward Plaintiffs when it: (i) misrepresented the Contract as ACA-compliant; and (ii) failed to utilize the appropriate "greatest of three" formula mandated under the ACA when processing Plaintiffs' claim for benefits pertaining to RMH's emergency air transfer of G. to Children's.

67. A serious public hazard exists because of BCBSOK's misconduct, as many individuals have the same type of health insurance plan.

68. The existence of a public hazard was reinforced in a similar lawsuit against BCBSOK and RMH regarding BCBSOK's failure to properly cover emergency air ambulance services when the United States District Court for the Western District of Oklahoma determined that it was in the public interest when BCBSOK entered into a rate agreement with RMH and retroactively applied the rate agreement to the charges assessed against the plaintiff's air ambulance bill, resulting in total satisfaction of the bill. *See* **Exhibit 12**, at *2.

69. Upon information and belief, BCBSOK enjoys increased profitability from unlawfully limiting such emergency coverage.

70. BCBSOK's refusal to lawfully cover the emergency services, failure to address the issues raised on appeal, and material misrepresentations regarding coverage were unreasonable under the circumstances, and BCBSOK thereby intentionally and maliciously violated its duty of good faith and fair dealing with Plaintiffs.

71. As a direct and proximate result of BCBSOK's breach of its duty of good faith and fair dealing, Plaintiffs have suffered harm, including mental anguish and loss of reputation (*e.g.*, impairment of credit), and have incurred costs and attorney fees, for which they entitled to recover damages, along with punitive damages exceeding $75,000.00.

COUNT III: FRAUD, CONSTRUCTIVE FRAUD AND MISREPRESENTATION AGAINST BCBSOK

72. Plaintiffs incorporate the allegations outside of this cause of action as if set forth in Count III in full.

73. BCBSOK intentionally represented, and continues to represent, the Contract to be ACA compliant.

74. Plaintiffs entered the Contract, relying on BCBSOK's representation that the Contract was ACA-compliant.

75. BCBSOK, in denying payment for the emergency air ambulance services based on the contention that RMH is an "out-of-network" provider, demonstrates that the Contract, as construed by BCBSOK, does not cover emergency services as "in-network."

76. Moreover, and in the alternative, BCBSOK materially and intentionally misrepresented to Plaintiffs that the out-of-pocket individual and family limit was $6,000 and $18,000, respectively, for out-of-network services.

77. Moreover, and in the alternative, the Allowable Charge for Out-of-Network Emergency Care Services set forth in the Contract differs materially from the ACA's requirements relative to coverage of emergency care services. Therefore, BCBSOK materially misrepresented the Contract as ACA-compliant.

78. BCBSOK had a duty to disclose its position concerning emergency air ambulance service charges, as well as the fact that it had no air ambulance "in-network."

79. Plaintiffs relied on BCBSOK's material misrepresentations and failure to disclose resulting in them suffering harm for which they are entitled to recover damages, along with punitive damages exceeding $75,000.00.

COUNT IV: DECLARATORY JUDGMENT

80. Plaintiffs incorporate the allegations outside of this cause of action as if set forth in Count IV in full.

81. Plaintiffs are judicially determined to owe the Alleged Balance and additional costs, attorney fees, and other charges assessed because BCBSOK failed or refused to perform its duties under the Contract.

82. Moreover, BCBSOK continues to misrepresent the Contract as ACA-compliant.

83. BCBSOK entered into an agreement with RMH in a 2017 case, which Judge Cauthron characterized as a "public benefit." **Exhibit 12**, at *2. Therefore, BCBSOK should have paid, on behalf of Plaintiffs, the amount it agreed was proper to RMH.

84. Because of these controversies, a declaratory judgment is both necessary and proper in order to set forth and determine the rights, obligations, and liabilities that exist among the parties.

85. Plaintiffs demand judgment against Defendant declaring BCBSOK's failure or refusal to pay the amount it agreed to pay to RMH violates applicable law, thus rendering the Contract noncompliant under the ACA, establishing a breach, and showing BCBSOK's bad faith.

86. BCBSOK owed its insureds a duty to pay the amounts it had agreed with RMH were owed for air ambulance transport.

IV. CLASS ACTION

87. Plaintiffs incorporate the allegations outside of these class claims as if set forth herein in full.

88. With respect to all Counts above, Plaintiffs bring this action pursuant to Fed. R. Civ. P. 23 on behalf of themselves and the following defined Class:

> Insureds under any BCBSOK Individual Comprehensive Health Care Services Benefits policy or BCBSOK Individual PPO Multistate Comprehensive Health Care Services Benefits policy (including both "Off Exchange" and "On Exchange" policies) from January 1, 2014, through present who received emergency services from an air ambulance provider for which a balance bill was allegedly due to said air ambulance provider from Insured and for which:
>
> (i) BCBSOK did not cover, and/or indemnify insured against, through retroactive application of its rate agreement with RMH deemed to be a public benefit (**Exhibit 12**, at *2); or

(ii) alternatively, BCBSOK's payments left an insured owing more than the applicable annual out-of-pocket limit.

89. Excluded from the Class are: 1) any Judge or Magistrate presiding over this action and their family members; 2) Defendant, Defendant's subsidiaries, parent companies, successors, predecessors, and any entity in which Defendant has a controlling interest, and their current or former officers and directors; 3) persons who properly execute and file a timely request for exclusion from the Class; and 4) the legal representatives, successors or assigns of any such excluded persons.

90. The named Plaintiffs are adequate representatives of the Class and will fairly represent and protect the Class because their interests do not conflict with the interests of the other Class members. Furthermore, Plaintiffs have retained counsel with extensive experience in health care law, civil trial practice, class actions, insurance law, and other related areas.

91. Additionally, Plaintiffs have the desire, competency, and capacity to serve as Class representative. Plaintiffs are personal victims of BCBSOK's conduct which occurred after emergency care was rendered. Plaintiffs have personal knowledge and experience with the facts of the current case, BCBSOK's conduct, BCBSOK's insurance policies, and the common language existing in those policies.

92. Members of the Class are so numerous that joinder of all members is impracticable, as, upon information and belief, and according to the Oklahoma Insurance Market Analysis prepared for the Oklahoma State Department of Health, it was estimated that individual insurance policies amounted to 171,800 policies in 2014 and 223,500

polices in 2015, and BCBSOK held a 79.3% Market Share of individual policies sold in 2014. This 79.3% market share equates to approximately 313,473 individual insurance policies sold by BCBSOK in 2014 and 2015 alone. While each of these insureds may not have received out-of-network emergency medical services and subsequently been balance billed, even if 1% of these individuals fall into the Class, the approximate number of Class members would be 3,315 individuals.

93. BCBSOK has acted on grounds generally applicable to the Class with respect to its contractual obligations, duty of good faith and fair dealing, and fraudulent conduct such that final relief with respect to the whole Class is appropriate. Ultimately, the conduct by BCBSOK harmed all Class members similarly in administration of the Class members' policies.

94. Plaintiffs' claims are typical of the entire Class because the Plaintiffs and each member of the Class were issued policies containing identical language pertaining to the subject matter of this litigation and sustained and continue to sustain similar injury arising out of BCBSOK's conduct and improper practices as more fully set forth throughout this Complaint.

95. A class action is appropriate as to all Counts identified herein because common issues and questions of fact and law exist among all members of the Class and such issues and questions of fact and law common to the Class members predominate over any questions affecting only individual members, and that a class action is superior to other available methods for fairly and efficiently adjudicating the present controversy. A class action is superior because: (A) the Class represents a number of individuals who may have

been issued individual balance bills of tens of thousands of dollars to $50,000.00 and, as a result, the class contains individuals who likely lack the funds to support a lawsuit against BCBSOK; (B) upon information and belief, no current pending litigation against BCBSOK incorporates the Class members' claims against BCBSOK as more fully set forth herein; (C) the interests of the Class, BCBSOK, and the judiciary in resolving these matters in one forum without the need for a multiplicity of actions are great; and (D) the difficulties likely to be encountered in the management of the class action will be slight in relation to the potential benefits achieved if each Class member were to bring their own lawsuit, not just those members who could afford to bring an individual lawsuit.

96. Plaintiffs are typical of the class both in harm and in claims. All proposed class members, including Plaintiffs, were issued identical form insurance policies from BCBSOK, received emergency care services/emergency medical transportation from an apparent out-of-network provider, and were subsequently balance billed without BCBSOK indemnifying or providing the appropriate amount of benefits as if the services were provided in-network all in violation of the law and in breach of BCBSOK's policies and the ACA. As Plaintiffs proceed in action against BCBSOK for Breach of Contract, Bad Faith, Misrepresentation and Fraud, they will inherently advance the claims and interest of the remainder of the Class members due to the identical contractual language and treatment among all Class members.

WHEREFORE, the Plaintiffs pray the following relief be granted:

i) Judgment against BCBSOK for breaching the Contract in the amount of the Alleged Balance of $45,149.14 plus attorney's fees, costs incurred, and additional damages arising by virtue of collections suit initiated by RMH;

ii) Judgment against BCBSOK for compensatory and punitive damages in excess of $75,000.00 for violating its duty of good faith and fair dealing;

iii) Judgment against BCBSOK for compensatory and punitive damages in excess of $75,000 for fraud and misrepresentation;

iv) Judgment against BCBSOK declaring that the Contract and policies included in the Class are not ACA-compliant;

v) Prejudgment and post-judgment interest as provided by law; for an award of all reasonable attorney's fees and costs incurred herein;

vi) An order of this Court to certify this case as a class action, to appoint the Plaintiffs as Class representatives, to appoint the undersigned attorneys as Class counsel, judgment against BCBSOK on behalf of the Class, along with punitive damages with respect to BCBSOK's improper conduct; and

vii) For any and all such other relief as the law allows or this Court deems in the interest of justice.

Dated April 27, 2018.

Respectfully submitted,

/S/ Noble McIntyre

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Attorneys for Plaintiffs Christina and Jeffrey Terry, on their own behalf and on behalf of their minor child, G. Terry, and on behalf of all others similarly situated

BlueCross BlueShield of Oklahoma

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

INDIVIDUAL PPO CONTRACT

COMPREHENSIVE HEALTH CARE SERVICES BENEFITS

YOU, THE MEMBER, HAVE THE RIGHT TO RETURN THIS CONTRACT FOR ANY REASON WITHIN 10 DAYS OF ITS DELIVERY AND HAVE ANY PAID PREMIUMS REFUNDED. If we do not return your premiums within 30 days from the date of cancellation, we must pay you interest on the proceeds. The interest we pay will be the same rate of interest as the average United States Treasury Bill rate of the preceding Calendar Year, as certified to the State Insurance Commissioner by the State Treasurer on the first regular business day in January of each year, plus two percentage points which shall accrue from the date of cancellation until the premiums are returned. In such event, the Contract shall be deemed to have been cancelled on the date the Contract was placed in the United States mail in a properly addressed, postpaid envelope; or if not so posted, on the date of delivery of such Contract to us. **If you return the Contract, we will have no liability for any health care or service which you have received.**

THIS IS YOUR CONTRACT OF HEALTH CARE AND SERVICES BENEFITS PROVIDED TO YOU BY BLUE CROSS AND BLUE SHIELD OF OKLAHOMA. PLEASE READ IT NOW, AS IT IS VALUABLE IN ASSISTING YOU TO FULLY UNDERSTAND YOUR BENEFITS.

IN THIS CONTRACT, "WE", "US", "OUR" AND THE "PLAN" MEAN BLUE CROSS AND BLUE SHIELD of OKLAHOMA. COVERED PERSONS ARE CALLED "SUBSCRIBERS", "YOU", OR "YOUR".

YOU ARE ELIGIBLE FOR COVERAGE UNDER THIS CONTRACT IF YOU ARE A MEMBER, AS DEFINED. YOUR DEPENDENTS, AS DEFINED, ARE ALSO ELIGIBLE PROVIDED YOU ARE COVERED.

COVERAGE UNDER THIS CONTRACT WILL CONTINUE IN FORCE AT THE OPTION OF YOU, THE MEMBER. HOWEVER, THE PLAN MAY NON-RENEW OR DISCONTINUE COVERAGE FOR YOU AND YOUR DEPENDENTS FOR THE FOLLOWING REASONS:

- FRAUD;
- TERMINATION OF THE PARTICULAR TYPE OF COVERAGE, OR ALL COVERAGE, IN THE INDIVIDUAL MARKET; OR
- RELOCATION OUTSIDE THE GEOGRAPHIC AREA ("NETWORK SERVICE AREA") DESIGNATED BY THE PLAN.

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.

A Division of Health Care Service Corporation,
a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Asso
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THIS CONTRACT MAY NOT BE CANCELLED BY YOU OR THE PLAN DURING A COVERAGE PERIOD, EXCEPT FOR NON-PAYMENT OF PREMIUMS, OR FOR FRAUD OR MATERIAL MISREPRESENTATION MADE IN ANY STATEMENT, APPLICATION, CLAIM OR OTHER FORM SUBMITTED TO OBTAIN THIS CONTRACT OR ANY OF ITS BENEFITS.

THE COVERAGE PERIOD IS THE PERIOD OF TIME COVERED BY YOUR MEMBER BILLING NOTICE, WHICH WAS ESTABLISHED AT THE BEGINNING OF YOUR FIRST COVERAGE PERIOD UNDER THIS CONTRACT.

You should carry your Identification Card with you at all times. Present your card to the Hospital, Physician, Pharmacy, or other Provider of health care when applying for admission or services.

Keep your health care protection. Please notify the Plan of any change in your address. You should also notify the Plan immediately if you become eligible to enroll for group health coverage.

If you move to an area serviced by another Blue Cross and Blue Shield Plan, you may transfer to the Blue Cross and Blue Shield Plan serving that area. Your coverage may be different from the coverage provided by this Contract.

Upon change of your marital status, either by marriage or divorce, the Plan must receive your written notification within 60 days. Upon your death, a surviving Subscriber should provide written notification to the Plan within 60 days in order that his/her membership rights may be continued.

In corresponding with the Plan, always refer to your identification number which appears on your Identification Card.

GENERAL: In consideration of the membership application and payment of premiums by the Member covered hereunder, Blue Cross and Blue Shield of Oklahoma (the Plan) agrees to make available to the Member, and any eligible Subscriber hereunder, a prepaid program of health care Benefits, subject to and administered in accordance with this Contract. The whole Contract herein consists of the membership application, the Identification Card and this Contract, including any provisions which may be added by Amendment or Endorsement. Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

The issuance of this Contract to you certifies that the Plan has accepted your application and that you, the Member named in the Identification Card, and your Dependents, if any, listed in your application or any supplemental application, along with any exhibits, appendices, addenda and/or other required information accepted by the Plan, as appropriate, are entitled to the Benefits set forth in this Contract.

THIS CONTRACT SETS FORTH A PROGRAM OF COMPREHENSIVE HEALTH CARE BENEFITS FOR INDIVIDUALS WHO HAVE MET THE PLAN'S ELIGIBILITY REQUIREMENTS FOR COVERAGE. THE BENEFITS DESCRIBED IN THIS CONTRACT WILL BE PROVIDED TO YOU OR IN YOUR BEHALF. IF YOU WERE A MEMBER OF THE PLAN ON THE DAY BEFORE THIS CONTRACT BECAME EFFECTIVE, YOUR COVERAGE WILL BE CONTINUOUS.

Jeffrey R Tibbauer

Blue Cross and Blue Shield of Oklahoma

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Important Information

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

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

YOUR PARTICIPATING PROVIDER NETWORK

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

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

HOW YOUR COVERAGE WORKS

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

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

In contrast, when care is received from a Provider who is not a Network Provider, *higher* Deductibles, Copayments and/or Coinsurance amounts may apply to your coverage. Refer to the *Schedule of Benefits* in the front of this Contract for additional details regarding your Benefits.

Through other network contracts with Blue Cross and Blue Shield of Oklahoma, many Oklahoma Hospitals, Physicians, and other Providers outside your network have also agreed to work together to help hold the line on health care cost increases. Although your Benefits will be reduced when you do not use Network Providers, using another contracting Provider offers some of the same advantages available to you within your Provider network:

- The Provider will file your claims for you (just as a Network Provider would do).
- Payment for Covered Services will be sent directly to the Provider.
- These Providers have agreed to charge Plan Subscribers no more than a "Maximum Reimbursement Allowance" for Covered Services. If your Provider charges more than our Allowable Charge for Covered Services, you are not responsible for the difference. **However, you will be responsible for the difference, if any, between the contracting Providers' Allowable Charge and the "Allowable Charge" which a Network Provider would have accepted for the same services.**

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

SELECTING A PROVIDER

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

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

THE BLUECARD® PROGRAM

As a Blue Cross and Blue Shield of Oklahoma Member, you enjoy the convenience of carrying your Identification Card – The BlueCard. The BlueCard Program allows you to use a Blue Cross and Blue Shield Physician or Hospital outside the state of Oklahoma and to receive the advantages of Network Provider Benefits and savings.

- **Finding a PPO Physician or Hospital**

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

- **Available Care Coast to Coast**

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

- **Remember to Always Carry the BlueCard**

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

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

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

How The BlueCard Program Works

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

Your Prescription Drug Program

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

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

How Your Prescription Drug Program Works

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

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

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

MEDICAL NECESSITY LIMITATION

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

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

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

PREAUTHORIZATION

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

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

If you utilize a Network Provider for Covered Services, that provider may request Preauthorization for the services. However, it is the Subscriber's responsibility to assure that the services are Preauthorized before receiving care.

- **Preauthorization Process for Inpatient Services**

  For an Inpatient facility stay, *you must request Preauthorization from the Plan before your scheduled admission*. The Plan will consult with your Physician, Hospital, or other facility to determine if Inpatient level of care is required for your illness or injury. The Plan may decide that the treatment you need could be provided just as effectively in a different (such as the Outpatient department of the Hospital, an Ambulatory Surgical Facility, or the Physician's office). If the Plan determines that your treatment does not require Inpatient care, you and your Provider will be notified of that decision. **If you proceed with an Inpatient stay without the Plan's approval, or if you do not ask the Plan for Preauthorization, your Benefits under this Contract 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 your use of an Out-of-Network Provider.

  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 Psychiatric Care Services**

  All Inpatient services related to treatment of Mental Illness (including severe Mental Illness), drug addiction, substance abuse or alcoholism must be Preauthorized by the Plan. Preauthorization is also required for the following Outpatient Psychiatric Care Services:

  - Psychological testing;
  - Neuropsychological testing;
  - Electroconvulsive therapy;
  - Intensive Outpatient Treatment.

  Preauthorization is not required for therapy visits to a Physician or other professional Provider licensed to perform Covered Services under this Contract. However, all services are subject to the "Concurrent Review" provisions set forth in this Contract.

  To request Preauthorization, the Subscriber or his/her Physician must call the Preauthorization number shown on the Subscriber's Identification Card **before** receiving treatment. The Plan will assist in coordination of the Subscriber's care so that his/her treatment is received in the most appropriate setting for his/her condition and that the Subscriber receives the highest level of Benefits under this Contract. If the Subscriber does not call for Preauthorization before receiving non-emergency services, Benefits for Covered Services may be subject to a reduction in Benefits, as set forth below under ***"Failure to Preauthorize".***

- **Preauthorization Process for Other Outpatient Services**

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

- **Preauthorization Request Involving Non-Urgent Care**

  Except in the case of a "Preauthorization Request Involving Urgent Care" (see below), the Plan will provide a written response to your Preauthorization request no later than 15 days following the date we receive your request. This period may be extended one time for up to 15 additional days, if 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 you in writing, prior to the expiration of the original 15-day period, that the extension is necessary, along with an explanation of the circumstances requiring the extension of time and the date by which the Plan expects to make the determination.

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

- **Preauthorization Request Involving Urgent Care**
  A *"Preauthorization Request Involving Urgent Care"* is any request for Medical Care or treatment with respect to which the application of the time periods for making non-urgent care determinations:

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

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

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

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

- **Failure to Preauthorize**

  If the Subscriber does not call for Preauthorization for **Inpatient services**, the admission will be subject to a $500 reduction in Benefits, if upon receipt of the claim, it is determined by the 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 Subscriber's responsibility to pay the full cost of the services received.

  If the Subscriber fails to obtain Preauthorization for **Outpatient** Psychiatric Care Services specified 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 you receive which is not a Covered Service under this Contract, or is not determined to be Medically Necessary, will be excluded from your Benefits. This applies even if Preauthorization approval is requested or received.

CONCURRENT REVIEW

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

ALLOWABLE CHARGE

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

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

REMEMBER ...

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

The 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:

  1. the Provider's billed charges; or
  2. the Plan's Non-Contracting Allowable Charge.

  The Non-Contracting Allowable Charge is developed from base Medicare reimbursements, excluding any Medicare adjustments using information on the claim, and adjusted by a predetermined factor established by the Plan. Such factor will not be less than 100% of the base Medicare reimbursement rate. For services for which a Medicare reimbursement rate is not available, the Allowable Charge for Non-Contracting Providers will represent an average contract rate for Network Providers adjusted by a predetermined factor established by the Plan and updated on a periodic basis. Such factor shall not be less than 100% of the average contract rate and will be updated not less than every two years. The Claims Administrator will utilize the same claim processing rules and/or edits that it utilizes in processing Participating Provider claims for processing claims submitted by Non-Contracting Providers which may also alter the Allowable Charge for a particular service. In the event the 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, you 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, you may call the Customer Service number shown on the back of your Identification Card.

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

  1. the median amount negotiated with network or contracting Providers for the Emergency Care Services furnished;
  2. the amount for the Emergency Care Services calculated using the same method the Plan generally uses to determine payments for Out-of-Network Provider services, but substituting the in-network or contracting cost-sharing provisions for the out-of-network or non-contracting Provider cost sharing provisions; or
  3. the amount that would be paid under Medicare for the Emergency Care Services.

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

- When Covered Services are received outside the state of Oklahoma from a Provider who does not have a written agreement with Blue Cross and Blue Shield of Oklahoma or with the local Blue Cross and Blue Shield Plan, the "Allowable Charge" will be determined by the Blue Cross and Blue Shield Plan (Host Plan) servicing the area. This Allowable Charge will be the amount the Host Plan uses for their own local members that obtain services from local Non-Contracting Providers.

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

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

AMENDMENTS

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

Because of changes in federal or state laws, or changes in your coverage, provisions called amendments may be added to your Contract.

Be sure to check for an amendment. It amends provisions or Benefits in your Contract.

IDENTIFICATION CARD

Whenever you call our offices for assistance, please have your Identification Card with you.

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

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

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

DESIGNATING AN AUTHORIZED REPRESENTATIVE

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

QUESTIONS

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

Or, you can write to us at one of the following addresses:

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

Member Complaints/Appeals
Appeal Coordinator – Customer Service Department
Blue Cross and Blue Shield of Oklahoma
P.O. Box 3235
Naperville, IL 60566-7235

For Other Inquiries/Correspondence
Blue Cross and Blue Shield of Oklahoma
P.O. Box 3239
Naperville, IL 60566-7239

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

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

Eligibility, Enrollment, Changes & Termination

This section tells:

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

WHO IS AN ELIGIBLE PERSON

Oklahoma Residents under age 65 on his/her Effective Date who reside or live in the geographic area ("Network Service Area") designated by the Plan, and who meet the eligibility requirements stated in the application as determined by the Plan, are eligible to apply for coverage under this Contract. A Subscriber may contact the Customer Service Department at the number shown on their Identification Card or access the Web site at www.bcbsok.com to determine if he/she is in the Network Service Area.

The Plan reserves the right to request proof of residency upon initial enrollment and from time to time thereafter as the Plan may require.

WHO IS AN ELIGIBLE DEPENDENT

As a Blue Cross and Blue Shield of Oklahoma Member, you have the option of selecting coverage under your membership for your Dependents, or you may apply for separate coverage in their names. If you elect to include them under your membership, an Eligible Dependent is defined as:

- your spouse or Domestic Partner under age 65 on his/her Effective Date; or
- your Dependent child. Wherever used in this Contract, "Dependent child" means your natural child, a stepchild, an eligible foster child, an adopted child or child Placed for Adoption (including a child for whom you or your spouse/Domestic Partner is a party in a legal action in which the adoption of the child is sought), under 26 years of age, regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status, eligibility for other coverage, or any combination of those factors. A child not listed above who is legally and financially dependent upon you or your spouse/Domestic Partner is also considered a Dependent child under this Contract, provided proof of dependency is provided with the child's application. A Dependent child who is medically certified as disabled and dependent upon you or your spouse/Domestic Partner is eligible to continue coverage beyond the limiting age, provided the disability began before the child attained the age of 26.

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

  The Plan also reserves the right to review a Physician's certificate of disability and/or request medical records or require a medical examination by an independent Physician to verify disability at the Subscriber's expense. The Plan will make the final determination regarding the Dependent's disability status.

CHILD-ONLY COVERAGE

Eligible Persons that have not attained age 21 may enroll as the sole Subscriber under this Contract. In such event, this Contract is considered child-only coverage and the following restrictions apply:

- Each child is enrolled individually as the sole Subscriber; the parent or legal guardian is not covered and is not eligible for Benefits under this Contract.
- No additional Dependents may be added to the enrolled child's coverage. Each child must be enrolled in his/her own Contract. Note: If a child covered under this Plan acquires a new eligible child of his/her own, the new eligible child may be enrolled in his/her own Contract if application for coverage is made within 60 days of the child's birth.
- If a child is under the age of 18, his/her parent, legal guardian, or other responsible party must submit the application for child-only insurance form, along with any exhibits, appendices, addenda and/or other required information to the Plan, as appropriate. For any child under 18 covered under this Contract, any obligations set forth in this Plan, any exhibits, appendices, addenda and/or other required information will be the obligations of the parent, legal guardian, or other responsible party applying for coverage on the child's behalf. Application for child-only coverage will not be accepted for an adult child that has attained age 21 as of the beginning of the Policy Year. Adult children (at least 18 years of age but no older than 20 years of age) who are applying as the sole Member under this Contract must apply for their own individual Contract and must sign or authorize the application(s).

APPLYING FOR COVERAGE

You may apply for coverage for yourself and/or your Dependents.

No eligibility rules or variations in premium will be imposed based upon your health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or any other health status related factor. You will not be discriminated against for coverage under this Plan on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation. Variations in the administration, processes or Benefits of this Contract that are based on clinically indicated, reasonable medical management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.

You may enroll in or change coverage for yourself and/or your Dependents during one of the following enrollment periods. Your and/or your Dependents' Effective Date will be determined by the Plan, depending upon the date your application is received, payment of the initial premiums no later than the day before the Effective Date, and other determining factors.

The Plan may require acceptable proof (such as copies of legal adoption or legal guardianship papers, or court orders) that an individual qualifies as a Dependent under this Plan.

INITIAL AND ANNUAL OPEN ENROLLMENT PERIODS/EFFECTIVE DATE OF COVERAGE

Initial and annual open enrollment periods have been designated during which you may apply for or change coverage for yourself and/or your Dependents.

The initial open enrollment period, during which you may enroll yourself and/or your Dependents for coverage is October 1, 2013, through March 31, 2014. When you enroll yourself and/or your Dependents before December 15, 2013, your and/or your Dependents' Effective Date will be January 1, 2014. When you enroll yourself and/or your Dependents between December 16, 2013, and March 31, 2014, your and/or your Dependents' Effective Date of coverage will be:

- The 1st day of the following month for all selections made between the 1st and the 15th of the month.

- The 1st day of the second following month for all selections made between the 16th and the last day of a given month.

For Benefit Periods beginning on or after January 1, 2015, the annual open enrollment period, during which you may enroll in or change coverage for yourself and/or your Dependents begins October 15th and extends through December 7th of the preceding year. When you enroll during the annual open enrollment period, your and/or your Dependents' Effective Date will be the following January 1st, unless otherwise designated by the Plan.

This section "Initial and Annual Open Enrollment Periods/Effective Date of Coverage" is subject to change by the Plan and/or applicable law, as appropriate.

SPECIAL ENROLLMENT PERIODS/EFFECTIVE DATES OF COVERAGE

Special enrollment periods have been designated during which you may change coverage for yourself and/or your Dependents. You must apply for coverage within 60 days from the date of a special enrollment event.

Except as otherwise provided below, if you apply between the 1st day and 15th day of the month, your Effective Date will be the 1st day of the following month, or if you apply between the 16th day and the end of the month, your and/or your Dependents' Effective Date will be the date determined by the Plan.

Special Enrollment Events:

- You experience a loss of Minimum Essential Coverage. New coverage for you and/or your Dependents will be effective on the first day of the month following the loss.
- You gain a Dependent or become a Dependent through marriage. New coverage for you and/or your Dependents will be effective on the first day of the following month.
- You gain a Dependent through birth, adoption or Placement for Adoption or court-ordered dependent coverage. New coverage for you and/or your Dependents' will be effective on the date of birth, adoption, or Placement for Adoption.

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

  If your membership includes at least ***one*** Dependent, coverage for a newborn will be effective on the date of birth and continue for 31 days. In order to extend the coverage beyond 31 days, your application to add coverage for the newborn must be received within 31 days following the child's birth; and you must make the required contribution for such coverage from the date of birth.
- Your enrollment or non-enrollment in a Qualified Health Plan ("QHP") is unintentional, inadvertent, or erroneous as evaluated and determined by the Plan.
- You adequately demonstrate that the QHP in which you are enrolled substantially violated a material provision of its contract in relation to you.
- You are determined newly eligible or newly ineligible for Advance Premium Tax Credit or have a change in eligibility for cost-sharing reductions, regardless of whether you are already enrolled in a QHP.
- You gain access to new QHPs as a result of a permanent move.
- You are enrolled in an individual non-calendar year health insurance policy. Your special open enrollment period begins on the date that is 30 calendar days prior to the date the policy year ends in 2014.
- Legal separation, divorce, death, or dissolution of a Domestic Partnership.

- Loss of Dependent status, such as attaining the limiting age to be eligible as a Dependent child under this Contract.
- Termination of employment, reduction in the number of hours of employment, or loss of coverage due to a policy no longer offering benefits to the class of similarly situated individuals that includes you and/or your Dependents.
- Loss of coverage through an HMO in the individual market because you and/or your Dependents no longer reside, live or work in the HMO service area.
- Loss of coverage through an HMO or other arrangement in the group market because you and/or your Dependents no longer reside, live or work in the HMO service area, and no other coverage is available to you and/or your Dependents.
- You incur a claim that would meet or exceed a lifetime limit on all Benefits.
- Your and/or your Dependent's employer ceases to contribute towards the employee's or Dependent's coverage (excluding COBRA continuation coverage).
- COBRA continuation of coverage is exhausted.

Loss of eligibility does not include a loss due to failure of the individual or the participant to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or any intentional misrepresentation of a material fact in connection with the plan).

Your application for special enrollment must be received by the Plan within 60 days following the loss of other coverage. **Coverage under special enrollment will be effective no later than the first day of the month after the Plan receives your application for enrollment for yourself or on behalf of your Dependent(s).**

Coverage resulting from any of the special enrollment events outlined above is contingent upon timely completion of the application and remittance of the appropriate premiums in accordance with the guidelines as established by the Plan.

CHANGES IN FAMILY MEMBERSHIP

You can change your coverage to remove one or more Dependents. The change will be effective at the end of the coverage period during which eligibility ceases.

In the event of a divorce, your spouse/Domestic Partner may wish to continue Blue Cross and Blue Shield of Oklahoma coverage. He/she may apply for equal or lesser coverage if his/her application is received by the Plan no later than 60 days after the divorce is granted. Your Dependent children may continue to be eligible under your membership, or your spouse/Domestic Partner may obtain his/her own Dependent coverage.

In the event of your death, your spouse/Domestic Partner and/or Dependent children may wish to continue Blue Cross and Blue Shield of Oklahoma coverage. They may apply for equal or lesser coverage if their application is received by the Plan no later than 60 days after your death.

A Dependent child who attains the age of 26 is no longer eligible under your coverage (unless medically certified as disabled). The Dependent may apply for equal or lesser coverage if his/her application is received by the Plan no later than 31 days after the end of the coverage period coinciding with or following their 26th birthday.

If the application for a membership transfer is not received within the time period specified above, enrollment will be permitted during the next annual open enrollment period.

NOTIFICATION OF ELIGIBILITY CHANGES

It is the Subscriber's responsibility to notify the Plan, as appropriate, of any change to a Subscriber's name or address. An address change may result in Benefit changes for you and your Dependents if you move out of the

Plan's Network Service Area. You may call Customer Service at the number shown on your Identification Card or log on to the Web site at www.bcbsok.com.

TERMINATION OF COVERAGE/WHEN COVERAGE ENDS

This Plan does not provide Benefits even if Preauthorization for such services was received from the Plan, that are received after a Member's coverage under this Contract is terminated.

When a Subscriber is no longer an Eligible Person or Eligible Dependent, coverage stops at the end of the coverage period during which eligibility ceases, except that, when a Subscriber ceases to be an Eligible Dependent by reason of death, coverage for that Subscriber will terminate on the date of death.

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

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

Termination of the Contract automatically ends all of your coverage at the same time and date.

WHAT WE WILL PAY FOR AFTER YOUR COVERAGE ENDS

If your coverage ends for any reason, your Benefits will end on the effective date and time of such termination. However, termination will not deprive you of Benefits to which you would otherwise be entitled for Covered Services incurred during a Hospital confinement which began before the date and time of termination. Benefits will be provided only for the lesser of:

- a period of time equal to the length of time you were covered under the Contract; or
- the duration of the Hospital confinement; or
- 90 days following termination of coverage.

We will have no liability for any Benefits under your Contract for Covered Services which are incurred after your coverage terminates, except as specified above.

TRANSFERS OUT OF THE NETWORK SERVICE AREA

A Member and/or his or her Eligible Dependents, if any, who relocate outside the Network Service Area are no longer eligible for coverage under this Contract. You may contact a Customer Service Representative for other coverage options that are available to you.

CONVERSION PRIVILEGE AFTER TERMINATION OF COVERAGE

If a Subscriber ceases to be eligible under this Contract, he/she may apply for continuous coverage under an Individual Conversion Contract, or under another Blue Cross and Blue Shield of Oklahoma individual Contract, subject to the underwriting and enrollment regulations applicable to the new coverage.

If you move to an area serviced by another Blue Cross Plan, you may transfer to the Blue Cross and Blue Shield Plan serving that area. *Coverage under this Contract is available only to Oklahoma Residents who reside or live within the Network Service Area.*

When you transfer to an Individual Conversion Contract, or to another individual Contract offered by Blue Cross and Blue Shield of Oklahoma or any another Blue Cross and Blue Shield Plan, your coverage may be different from the coverage provided by this Contract.

Written application for an Individual Conversion Contract must be received by Blue Cross and Blue Shield of Oklahoma no later than 31 days after you cease to be eligible under this Contract.

An Individual Conversion Contract will not be available to a Subscriber who:

- is eligible for coverage under a group having a contract with the Plan; or
- is enrolled under an individual Contract through Blue Cross and Blue Shield of Oklahoma or any other Blue Cross and Blue Shield Plan.

CERTIFICATES OF CREDITABLE COVERAGE

A Certificate of Creditable Coverage will be provided, without charge, for individuals who are or were covered under the Contract upon the occurrence of any of the following events:

- **When Coverage Ceases**

  An automatic Certificate of Creditable Coverage is to be provided at the time the individual's coverage ceases.

- **Any Individual Upon Request**

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

The Certificate of Creditable Coverage gives detailed information about how long you had coverage under the Contract. This information may be used to demonstrate "Creditable Coverage" to your new health plan.

DELETING A DEPENDENT

You can change your coverage to delete Dependents. The change will be effective at the end of the coverage period during which eligibility ceases.

WHEN YOU TURN AGE 65

You may terminate coverage when you turn age 65 when Medicare takes over. You may apply for one of the Medicare supplement coverage options offered by Blue Cross and Blue Shield of Oklahoma.

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

REINSTATEMENT

When coverage lapses for failure to pay premiums for this Contract, the subsequent acceptance of such premium payments by the Plan or its duly authorized agents shall reinstate the Contract. For purposes of this reinstatement provision, mere receipt and/or negotiation of a late premium payment does not constitute acceptance. The reinstated Contract shall cover only loss resulting from accidental injury sustained after the date of reinstatement and loss due to sickness beginning more than 10 days after such date. In all other respects, the Subscriber and the Plan shall have the same rights hereunder as they had under the Contract immediately before the due date of the defaulted premiums, including the right of the Subscriber to apply the period of time this Contract was in effect immediately before the due date of the defaulted premiums toward satisfaction of any waiting periods for Benefits, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium payments accepted in connection with a reinstatement shall be applied to a period for which premiums have not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

REINSTATEMENT OF COVERAGE FOLLOWING MILITARY ACTIVATION

A Subscriber who is an Oklahoma Resident may request reinstatement of coverage under this Contract if the termination of coverage results from the Subscriber's activation for military service, or from the Subscriber's eligibility for a federal government-sponsored health insurance program resulting from such military activation.

Reinstatement shall be granted into the same coverage the Subscriber held prior to termination, in the same rating tier the Subscriber held prior to activation, and subject to the payment of the current premium charged to other persons of the same age and gender that are covered under the same coverage option.

Except for the birth or adoption of a Dependent child that occurs during the period of activation, reinstatement of coverage must be into the same membership type, or a membership type covering fewer persons, as such Subscriber held prior to lapsing the coverage, and at the same or higher Deductible level.

Reinstatement rights are available only if the Subscriber is an Oklahoma Resident who resides or lives in the Network Service Area and provides written notice to the Plan within 31 days following the later of deactivation or loss of coverage under the federal government-sponsored health insurance program. The Plan may request proof of loss and the timing of the loss of such government-funded coverage in order to determine the Subscriber's eligibility for reinstatement. These reinstatement rights shall not be available to any Subscriber if the activated person is discharged from the military under other than honorable conditions.

RESCISSION OF COVERAGE

Any act, practice or omission that constitutes fraud or making an intentional misrepresentation of material fact with the intent to deceive the Plan on the Member's application, may result in the cancellation of the Member's coverage (and/or coverage of any Dependents), retroactive to the effective date, subject to 30 days' prior notification. Rescission is defined as a cancellation or discontinuance of coverage that has a retroactive effect. In the event of such cancellation, the Plan may deduct from the premium refund any amounts made in claim payments during this period, and the Member may be liable for any claims payment amount greater than the total amount of premiums paid during the period for which cancellation 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 Contract, 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 Contract 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 the ***Complaint/Appeal Procedures*** section for appeal rights concerning rescission and/or reformation.

Comprehensive Health Care Services

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

PREVENTIVE CARE SERVICES

Any of the following Covered Services performed by a Provider.

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 Subscribers under age 19).

1. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF");
2. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved;
3. Evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") for infants, children, and adolescents; and
4. With respect to women, such additional preventive care and screenings, not described in item 1 above, as provided for in comprehensive guidelines supported by the HRSA. 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.
   - Contraceptive Services – Benefits will be provided for the following contraceptive services when prescribed by a licensed Provider for women with reproductive capacity:
     - contraceptive counseling;
     - FDA-approved prescription devices and medications;
     - over-the-counter contraceptives; and
     - sterilization procedures (tubal ligation), but not including hysterectomy.

     Coverage includes contraceptives in the following categories:

     - progestin-only contraceptives;
     - combination contraceptives;
     - emergency contraceptives;
     - extended-cycle/continuous oral contraceptives;
     - cervical caps;
     - diaphragms;
     - implantable contraceptives;
     - intra-uterine devices;
     - injectables;
     - transdermal contraceptives and
     - vaginal contraceptive devices.

NOTE: Prescription contraceptive medications are covered under the ***Outpatient Prescription Drug Benefits and Related Services*** section of this Contract, *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 Information list. You may access the web site at www.bcbsok.com or contact Customer Service at the toll-free number on your Identification Card.

When obtaining the items noted above, you may be required to pay the full cost and then submit a claim form with itemized receipts to the Plan for reimbursement. Please refer to the ***Claims Filing Procedures*** section of this Contract 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 your coverage.

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

The Preventive Care Services described in items 1 through 4 above may change as the USPSTF, CDC, and HRSA guidelines are modified. For more information you may access the Web site at www.bcbsok.com or contact Customer Service at the toll-free number listed on your 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, you may be responsible for any applicable Deductible, Copayment and/or Coinsurance amounts for the office visit only. If an office visit and the Preventive Care Service are not billed separately and the primary purpose of the visit was not the Preventive Care Service, you may be responsible for any applicable Deductible, Copayment, and/or Coinsurance amounts for the office visit including the Preventive Care Service.

Examples of Covered Services included are (1) routine annual physicals, including immunizations, well-child care, cancer screening mammograms, bone density tests; and screening for prostate cancer and colorectal cancer; (2) smoking cessation counseling services; and (3) healthy diet counseling and obesity screening/counseling.

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

Covered Services ***not*** included in items 1 through 4 above may be subject to any Deductibles, Copayments, Coinsurance and/or dollar maximums applicable to your coverage.

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

Coverage for the Preventive Care Services specified in items 1 through 4 above shall be provided in accordance with the terms and conditions of the appropriate Benefit section of this Contract (for example: "Hospital Services", "Surgical/Medical Services", "Diagnostic Services" or "Outpatient Prescription Drugs and Related Services".)

EMERGENCY CARE SERVICES

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

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

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

HOSPITAL SERVICES

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

- **Bed and Board**

  Bed, board and general nursing service in:

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

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

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

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

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

- **Surgery**

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

- **Routine Nursery Care**

  - Inpatient Hospital Services for Routine Nursery Care of a newborn Subscriber.
  - Routine Nursery Care does not include treatment or evaluation for medical or surgical reasons during or after the mother's maternity confinement. In the event the newborn requires such treatment or evaluation while covered under this Contract:
    - the infant will be considered as a Subscriber in its own right and will be entitled to the same Benefits as any other Subscriber under this Contract; and
    - a separate Deductible will apply to the newborn's Hospital confinement.

SURGICAL/MEDICAL SERVICES

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

- **Surgery**

  Benefits include visits before and after Surgery.

  - If an incidental procedure[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.**
  - When more than one surgical procedure is performed through more than one route of access during one operation, you are covered for:
    - the primary procedure; plus
    - 50% of the amount available for each of the additional procedures had those procedures been performed alone.
  - Sterilization, regardless of Medical Necessity.

- **Assistant Surgeon**

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

- **Anesthesia**

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

- **Inpatient Medical Services**

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

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[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.*

- Inpatient Medical Care Visits

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

- Intensive Medical Care

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

- Concurrent Care

  - Care for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery.
  - If the nature of the illness or injury requires, care by two or more Physicians during one Hospital stay.

- Consultation

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

- Newborn Well Baby Care

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

- **Outpatient Medical Services**

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

  - Emergency Accident Care

    Treatment of accidental bodily injuries.

  - Emergency Medical Care

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

  - Home, Office, and Other Outpatient Visits

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

  - Contraceptive Devices

    Contraceptive devices which are:

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

  - Audiological Services

    Audiological services and hearing aids, limited to:

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

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

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
- Chemotherapy

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

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

  Benefits for Outpatient Physical Therapy, Outpatient Occupational Therapy and Outpatient Speech Therapy (including visits to the Subscriber's home) are limited to the number of visits specified in the *Schedule of Benefits for Comprehensive Health Care Services* in the front of this Contract.

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 or health 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 Contract after childbirth, except as otherwise provided in this section; and
  - Postpartum home care following a vaginal delivery if childbirth occurs at home or in a birthing center licensed as a birthing center. The coverage shall provide for one home visit within 48 hours of

childbirth by a licensed health care Provider whose scope of practice includes providing postpartum care. The visits shall include, at a minimum:

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

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

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

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

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 meet the criteria established by the Plan for assessing** and **selecting Providers for transplants.**

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

- **DEFINITIONS**

  In addition to the definitions listed under the ***Definitions*** section of this Contract, 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 or Unproven nature of certain care and services under the Contract. Preauthorization is subject to all conditions, exclusions and limitations of the Contract. Preauthorization does not guarantee that all care and services a Subscriber receives are eligible for Benefits under the Contract.

- **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 the Contract, Benefits will be provided for Covered Services rendered by a Hospital, Physician, or other Provider for the human organ and tissue transplant procedures set forth below.

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

- **EXCLUSIONS AND LIMITATIONS APPLICABLE TO ORGAN/TISSUE/BONE MARROW TRANSPLANTS**
  - The transplant must meet the criteria established by the Plan for assessing and performing organ or tissue transplants, or Bone Marrow Transplant procedures, as set forth in the Plan's written medical policies.
  - In addition to the Exclusions set forth elsewhere in this Contract, 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 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 Subscriber recipient.
    - All services, provided directly for or relative to any organ or tissue transplant, or Bone Marrow Transplant procedure which is not specifically listed as a Covered Service in this Contract.

- **DONOR BENEFITS**

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

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

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

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

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

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

AMBULATORY SURGICAL FACILITY SERVICES

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

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

SERVICES RELATED TO TREATMENT OF AUTISM AND AUTISM SPECTRUM DISORDERS

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

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

Benefits for services related to treatment of autism and autism spectrum disorders are subject to the following limitations:

- **Subscribers under age six shall be entitled to the number of visits specified in the *Schedule of Benefits for Comprehensive Health Care Services* in the front of this Contract for Physical Therapy, Occupational Therapy and Speech Therapy.**

- **Subscribers age six and older are subject to the limitations specified under "Outpatient Therapy Services", as set forth in the *Comprehensive Health Care Services* section of this Contract.**

PSYCHIATRIC CARE SERVICES

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

- Inpatient Facility Services

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

- Inpatient Medical Services

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

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

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

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

- Outpatient Psychiatric Care Services

  - Facility and Medical Services

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

  - Day/Night Psychiatric Care Services

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

- Drug Addiction, Substance Abuse and Alcoholism

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

AMBULANCE SERVICES

- Medically Necessary transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured:
  - From your home to a Hospital;
  - From the scene of an accident or medical emergency to a Hospital;
  - Between Hospitals;
  - Between a Hospital and a Skilled Nursing Facility;
  - From the Hospital to your home.

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

PRIVATE DUTY NURSING SERVICES

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

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

REHABILITATION CARE

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

Rehabilitation Care is limited to the number of Inpatient days specified in the *Schedule of Benefits for Comprehensive Health Care Services* in the front of this Contract.

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

SKILLED NURSING FACILITY SERVICES

Covered Inpatient Hospital Services and supplies rendered to an Inpatient of an eligible Skilled Nursing Facility.

Skilled Nursing Facility Services are limited to the number of Inpatient days specified in the *Schedule of Benefits for Comprehensive Health Care Services* in the front of this Contract.

Skilled Nursing Facility Services are subject to the Preauthorization requirements of this Contract **(see "*Important Information*"). 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** Contract.

No Benefits are **available**:

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

HOME HEALTH CARE SERVICES

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

- Medical and surgical supplies;
- Prescribed drugs;
- Oxygen and its administration;
- **Home visits for the following, limited to the number of visits specified in the *Schedule of Benefits for Comprehensive Health Care Services* in the front of this Contract:**
  - Professional services of an RN, LPN, or LVN;

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

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

We do 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;
- Intravenous drug, fluid, or nutritional therapy, **except when you have received Preauthorization from the Plan for these services.**

HOSPICE SERVICES

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

Hospice Services are subject to the Preauthorization requirements of this Contract (see "*Important Information*"). 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 Contract.

DENTAL SERVICES FOR ACCIDENTAL INJURY

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

DIABETES EQUIPMENT, SUPPLIES AND SELF-MANAGEMENT SERVICES

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

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

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

  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 Contract (for example: "Outpatient Prescription Drugs and Related Services", "Durable Medical Equipment" and "Home Health Care Services".)

SERVICES RELATED TO CLINICAL TRIALS

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

- A federally funded or approved trial;
- A clinical trial conducted under an FDA investigational new drug application; or
- A drug trial that is exempt from the requirement of an FDA investigational new drug application.

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

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

DURABLE MEDICAL EQUIPMENT

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

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

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

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

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

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 Contract. Eyeglass lens, soft lens and contact lens are included if prescribed as part of postoperative treatment for cataract extraction. Implantation or removal of breast prostheses is a Covered Service only in connection with reconstructive breast Surgery performed solely and directly as a result of mastectomy which is Medically Necessary. **Benefits for replacement appliances will be provided only when Medically Necessary.**

ORTHOTIC DEVICES

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

Benefits will be provided for the following orthotic devices:

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

Not covered are:

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

Benefits for orthotic devices are limited to the maximum amount specified in the *Schedule of Benefits for Comprehensive Health Care Services* in the front of this Contract.

WIGS OR OTHER SCALP PROSTHESES

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

Benefits are limited to the maximum amount specified in the *Schedule of Benefits for Comprehensive Health Care Services* in the front of this Contract.

Outpatient Prescription Drug Benefits and Related Services

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

COVERED SERVICES

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

- Prescription Drugs dispensed for a Subscriber's Outpatient use, when recommended by and while under the care of a Physician or other Provider.
- Injectable insulin and insulin products, but only when dispensed in accordance with a written prescription by a licensed Physician or other Provider even though a prescription may not be required by law.
- Oral contraceptives, when prescribed by a licensed Physician or other Provider.
- Prescription Drugs prescribed for treatment of attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD), subject to the Plan's requirements for Preauthorization.
- Oral Chemotherapy when prescribed by a licensed Physician.
- Self-injectable and other self-administered Prescription Drugs (including Chemotherapy), when dispensed by a Pharmacy. Self-administered drugs purchased from a Physician and administered in his/her office are not covered. Many self-injectable/self-administered drugs are classified as "Specialty Pharmacy Drugs" and may be purchased from a Participating Specialty Pharmacy.
- Specialty Pharmacy Drugs (when dispensed by a Pharmacy participating in the Specialty Pharmacy Network).
- Vaccinations (when administered by a participating Retail Pharmacy Vaccination Network Provider). Visit the Plan's Web site at www.bcbsok.com for a current listing of vaccines available through this coverage. NOTE: Vaccinations administered through a Participating Retail Pharmacy Vaccination Network Provider are not subject to the Deductible, Copayment and/or Coinsurance provisions of this Contract.

RETAIL PHARMACY PROGRAM

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

EXTENDED RETAIL PRESCRIPTION DRUG SUPPLY PROGRAM

Your coverage includes Benefits for a 90-day supply of Maintenance Prescription Drugs purchased from a Participating Prescription Drug Provider which may only include retail or home delivery pharmacies. Benefit amounts are listed in the ***Schedule of Benefits for Outpatient Prescription Drugs and Related Services.*** Your cost will be the appropriate Deductible, Copayment and/or Coinsurance amount indicated in the ***Schedule of Benefits for Outpatient Prescription Drugs and Related Services.***

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

MAIL-ORDER PHARMACY PROGRAM

The Plan has selected a Mail-Order Pharmacy to fill and deliver maintenance (long-term) medications. ***You are encouraged to fill these Maintenance Prescription Drugs through the Mail-Order Pharmacy.***

The Mail-Order Pharmacy Program provides delivery of Maintenance Prescription Drugs directly to your home address. All items that are covered under the Mail-Order Pharmacy Program are the same items that are covered under the Retail Pharmacy Program and are subject to the same limitations and exclusions. **Items covered through a Specialty Pharmacy may not be covered through the Mail-Order Pharmacy Program.** NOTE: Prescription Drugs and other items may not be mailed outside the United States.

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

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

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

SPECIALTY PHARMACY PROGRAM

The Specialty Pharmacy Drug delivery service integrates Specialty Pharmacy Drug Benefits with your overall medical and Prescription Drug Benefits. This program provides delivery of medications directly to your health care Provider for administration or to the home of the patient that is undergoing treatment for a complex medical condition. **Due to special storage requirements and high cost, Specialty Drugs are not covered unless obtained through the Specialty Pharmacy Drug Program.**

The Specialty Pharmacy Drug Program delivery service offers:

- Coordination of coverage among you, your health care Provider and the Plan;
- Educational materials about the patient's particular condition and information about managing potential medication side effects;
- Syringes, sharps containers, alcohol swabs and other supplies with every shipment for FDA approved self-injectable/self-administered medications; and
- Access to a pharmacist for urgent medication issues 24 hours a day, seven days a week, 365 days each year.

A list identifying these Specialty Pharmacy Drugs is available by accessing the Web site at www.bcbsok.com or by contacting Customer Service at the toll-free number on your Identification Card. Your cost will be the appropriate Deductible, Copayment and/or Coinsurance amount indicated in the ***Schedule of Benefits for Outpatient Prescription Drugs and Related Services.***

PAYMENT OF BENEFITS

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

- Benefits for Prescription drugs are available to the Subscriber only:
  - in accordance with a Prescription Order; and
  - after the Subscriber has met the Deductible, if applicable; and
  - after the Subscriber has incurred charges equal to the Copayment and/or Coinsurance applicable to each Prescription Order. **If the charge for your prescription is *less* than your** Copayment and/or Coinsurance**, you will pay the lesser amount.**
- When Prescription Drugs and related services are dispensed by a Participating Pharmacy, the Plan will pay directly to the Pharmacy the Allowable Charge for the drugs, less the applicable Deductible, Copayment and/or Coinsurance amount specified in the ***Schedule of Benefits for Outpatient Prescription Drugs and Related Services.***
- If your Prescription Order is filled by an Out-of-Network Pharmacy, you will need to pay the full cost of the drugs directly to the Pharmacy and then submit a claim to the Plan in order to receive any Benefits under this program. In addition to any Deductible, Copayment and/or Coinsurance amounts applicable to your coverage, you will be responsible for the cost difference, if any, between the Pharmacy's billed charges and the Allowable Charge determined by the Plan. **NOTE: Vaccinations administered by a Pharmacy that is not a Participating Retail Pharmacy Vaccination Network Provider are not covered under this *Outpatient Prescription Drugs and Related Services* section.**

PRESCRIPTION DRUG SUPPLY/DISPENSING LIMITS

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

- **Benefit Supply Limits per Prescription**

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

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

  - ***Retail Pharmacy*** and ***Specialty Pharmacy Network Providers*** – During each one-month period, up to a 30-day supply for "non-maintenance" and Specialty Pharmacy Drugs.
  - ***Extended Retail Prescription Drug Supply Program*** and ***Mail-Order Pharmacy Program*** – During each three-month period, up to a 90-day supply for drugs designated by the Plan as Maintenance Prescription Drugs. If less than a 90-day supply is ordered, the extended retail supply/mail-order Copayment and/or Coinsurance will still apply.

  A separate Copayment and/or Coinsurance amount will apply to each fill of a medication having a unique strength, dosage or dosage form.

  A separate Copayment and/or Coinsurance amount will apply to each fill of a prescription purchased on the same day for insulin and insulin syringes.

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

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

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

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

  In addition to the supply limits stated above and regardless of the quantity of a Covered Drug prescribed by a Physician, the Plan has the right to establish dispensing limits on Covered Drugs. These limits, which are based upon FDA dosing recommendations and nationally recognized clinical guidelines, identify gender or age restrictions, and/or the maximum quantity of a drug (or member of a drug class) that can be dispensed to you over a specific period of time. Such limits are in place to encourage appropriate drug use, patient safety, and reduce stockpiling. Benefits for a Covered Drug may also be denied if the drug is dispensed or delivered in a manner intended to avoid the Plan-established dispensing limit. If you need a drug quantity that exceeds the dispensing limit, ask your doctor to submit a request for review to the Plan on your behalf. The Preauthorization request will be approved or denied after the clinical information submitted by the prescribing Provider has been evaluated by the Plan.

- **Controlled Substances Limitation**

  If the Plan determines that a Subscriber may be receiving quantities of controlled substance medications not supported by FDA approved dosages or recognized treatment guidelines, any Benefits for additional drugs may be subject to a review for Medical Necessity, appropriateness and other restrictions.

EXCLUSIONS AND LIMITATIONS

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

- Drugs which by law do not require a Prescription Order from an authorized Provider (except insulin, insulin analogs, insulin pens, and prescriptive and nonprescriptive oral agents for controlling blood sugar level); and drugs, insulin or covered devices for which no valid Prescription Order is obtained.
- Over-the-counter drugs and medications, except those prescribed by a Physician or other Provider as part of the "Preventive Care Services" as defined in this Contract.
- Devices or Durable Medical Equipment of any type (even though such devices may require a Prescription Order), such as, but not limited to, therapeutic devices, artificial appliances, or similar devices (**except** disposable hypodermic needles and syringes for self-administered injections).
- Administration or injection of any drugs (except for vaccines administered by a Participating Pharmacy).
- Vitamins (**except** those vitamins which by law require a Prescription Order and for which there is **no** non-prescription alternative).
- Drugs dispensed in a Physician's office or during confinement while a patient in a Hospital, or other acute care institution or facility, including take-home drugs; and drugs dispensed by a nursing home or custodial or chronic care institution or facility.
- Covered Drugs, devices, or other Pharmacy services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States (including but not limited to, any services or supplies for which benefits are payable under Part A and Part B of Title XVIII of the Social Security Act (Medicare), or the laws, regulations or established procedures of any county or municipality, except any program which is a state plan for medical assistance (Medicaid), or any Prescription Drug which may be properly obtained without charge under local, state, or federal programs, unless such exclusion is expressly prohibited by law;

provided, however, that this exclusion shall not be applicable to any coverage held by the Member for Prescription Drug expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.

- Any services provided or items furnished for which the Pharmacy normally does not charge.
- Covered Drugs for which the Pharmacy's usual and customary charge to the general public is less than or equal to the Copayment and/or Coinsurance amount provided under this Contract.
- Infertility and fertility medications.
- Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.
- Drugs required by law to be labeled: "Caution — Limited by Federal Law to Investigational Use," or Experimental drugs, even though a claim is made for the drugs.
- Covered Drugs dispensed in quantities in excess of the amounts stipulated in this ***Outpatient Prescription Drugs and Related Services*** section; or refills of any prescriptions in excess of the number of refills specified by the Physician or by law; or any drugs or medicines dispensed more than one year following the Prescription Order date.
- Drugs which are not approved by the U.S. Food and Drug Administration (FDA) for a particular use or purpose or when used for a purpose other than the purpose for which the FDA approval is given, except as required by law or regulation. This exclusion is not applicable to the coverage of the off-label use of Prescription Drugs for the treatment of cancer or the study of oncology in accordance with Oklahoma law.
- Fluids, solutions, nutrients, medications (including all additives and Chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous, intramuscular (in the muscle), intrathecal (in the spine), or intraarticular (in the joint) injection in the home setting, except as specifically provided in this Contract. NOTE: This exception does not apply to dietary formula necessary for the treatment of phenylketonuria (PKU) or other heritable diseases.
- Drugs prescribed and dispensed for the treatment of obesity or for use in any program of weight reduction, weight loss, or dietary control.
- Drugs the use or intended use of which would be illegal, unethical, imprudent, abusive, not Medically Necessary, or otherwise improper.
- Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the Identification Card.
- Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction which is not covered under this Contract, or for which Benefits have been exhausted.
- Rogaine, minoxidil or any other drugs, medications, solutions or preparations used or intended for use in the treatment of hair loss, hair thinning or any related condition, whether to facilitate or promote hair growth, to replace lost hair, or otherwise.
- Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.
- Prescription Orders for which there is an over-the-counter product available with the same active ingredient(s), in the same strength, unless otherwise determined by the Plan.
- Athletic performance enhancement drugs.
- Drugs to treat sexual dysfunction or erectile dysfunction, including, but not limited to, sildenafil citrate (Viagra), phentolamine (Regitine), alprostadil (Prostin, Edex, Caverject), and apomorphine.
- Compounded medications. For purposes of this exclusion, "compounded medications" are substances made by mixing, reconstituting or other such acts, not in accordance with directions contained in Food and Drug

Administration (FDA) approved labeling provided by the product's manufacturer and other FDA-approved manufacturer directions consistent with that labeling.

- Replacement of drugs or other items that have been lost, stolen, destroyed, or misplaced.
- Shipping, handling, or delivery charges.
- Prescription Drugs required for international travel or work.
- Certain drug classes where there are over-the counter alternatives available.
- Drugs which are repackaged by anyone other than the original manufacturer.

BRAND NAME DRUG EXCLUSION

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

PRESCRIPTION DRUG PREAUTHORIZATION PROCESS

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

A form of Preauthorization is our Step Therapy program – a "step" approach to providing Benefits for certain medications your Physician or other Provider prescribes for you. This means that you may first need to try one or more "prerequisite" medications before certain high-cost medications are approved for coverage under your Prescription Drug program. Although you may currently be on therapy, your claim may need to be reviewed to see if the criteria for coverage of further treatment has been met. A documented treatment with a Generic Drug or brand name therapeutic alternative medication may be required for continued coverage of the Brand Name Drug.

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

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

  You can obtain a listing of the drugs which require Preauthorization by contacting a Customer Service Representative at the number on the back your Identification Card. Or, you may request a listing by writing to:

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

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

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

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

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

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

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

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

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

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

- If Preauthorization is approved for the drug, you may return to the Pharmacy to obtain the full Prescription Order, subject to any Deductible, Copayment and/or Coinsurance amount applicable to the balance of the drug quantity dispensed.
- If the Preauthorization is denied, you may obtain your Prescription Order by paying the full cost for the drugs.
- Regardless of the Plan's decision, you will be notified in writing regarding the outcome of your Preauthorization approval request.

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

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

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

To view a listing of the drugs which are included in the Preauthorization/Step Therapy program, please visit our Web site at www.bcbsok.com. If you have questions about Step Therapy, or any other aspects of the Preauthorization process, please call a Customer Service Representative at the number shown on your Identification Card for assistance.

Exclusions

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

WHAT IS NOT COVERED

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

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

- For cosmetic Surgery or complications resulting therefrom, including Surgery to improve or restore your appearance, unless:
  - needed to repair conditions resulting from an accidental injury; or
  - for the improvement of the physiological functioning of a malformed body member resulting from a congenital defect.

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

  Benefits are not provided for dental implants, grafting of alveolar ridges, or for any complications arising from such procedures.
- For or related to Inpatient treatment of any non-covered dental procedure, except that coverage shall be provided for Hospital Services, Ambulatory Surgical Facility Services, and anesthesia services associated with any Medically Necessary dental procedure when provided to a Subscriber who is:

- severely disabled; or
- eight years of age or under and who has a medical or emotional condition which requires hospitalization or general anesthesia for dental care; or
- four years of age or under, who in the judgment of the practitioner treating the child, is not of sufficient emotional development to undergo a Medically Necessary dental procedure without the use of anesthesia.

- For eyeglasses, contact lenses or examinations for prescribing or fitting them, except for:
  - aphakic patients (including lenses required after cataract Surgery) and soft lenses or sclera shells to treat disease or injury;
  - vision examinations performed in connection with the diagnosis or treatment of disease or injury; or
  - services specified under "Preventive Care Services" or in the "Pediatric Vision Care Addendum".
- For eye Surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).
- For hearing aids, tinnitus maskers, or examinations for prescribing or fitting them, except as specified for Subscribers under age 18. Hearing examinations not related to the prescription or fitting of hearing aids will be a Covered Service only when performed in connection with the diagnosis or treatment of disease or injury, or as specified under "Preventive Care Services".
- For transsexual Surgery or any treatment leading to or in connection with transsexual Surgery.
- For diagnosis, treatment or medications for infertility and fertilization procedures. Examples include any form of: artificial insemination; ovulation induction procedures; in vitro fertilization; embryo transfer; or any other procedures, supplies or medications which in any way are intended to augment or enhance your reproductive ability.
- For treatment of sexual problems not caused by organic disease
- For treatment of obesity, including morbid obesity, regardless of the patient's history or diagnosis, including but not limited to the following: weight reduction or dietary control programs; surgical procedures; prescription or nonprescription drugs or medications such as vitamins (whether to be taken orally or by injection), minerals, appetite suppressants, or nutritional supplements; and any complications resulting from weight loss treatments or procedures.
- For smoking cessation programs, not including counseling as specified under "Preventive Care Services".
- For medication, drugs or hormones to stimulate growth.
- For or related to acupuncture, whether for medical or anesthesia purposes.
- For conditions related to hyperkinetic syndromes, learning disabilities, behavioral problems, mental retardation, or for Inpatient confinement for environmental change. This exclusion ***shall not*** apply to the following Medically Necessary services:
  - Services of a Physician or other Provider (except for neuropsychological testing) related to the diagnosis and treatment of attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD); or
  - Prescription Drug therapy for treatment of ADD/ADHD.
- For unspecified developmental disorders or autistic disease of childhood, except as specified in the ***Comprehensive Health Care Services*** section under "Services Related to Treatment of Autism and Autism Spectrum Disorders."
- For or related to applied behavior analysis.

- For family or marital counseling.
- For hippotherapy, equine assisted learning, or other therapeutic riding programs.
- For which the Provider of service customarily makes no direct charge to a Subscriber.
- For treatment of temporomandibular joint dysfunction, including but not limited to diagnostic procedures, splints, orthodontic/orthopedic appliances, restorations necessary to increase vertical dimension or to restore or maintain functional or centric occlusion, alteration of teeth or jaws, Physical Therapy, and medication and behavioral modification related to conditions of temporomandibular joint syndrome or any other conditions involving the jaw joint, adjacent muscles or nerves, regardless of cause or diagnosis.
- For or related to transplantation of donor organs, tissues or bone marrow, except as specified under "Human Organ, Tissue and Bone Marrow Transplant Services."
- For Physician standby services.
- For Continuous Passive Motion (CPM) devices used in treatment of the shoulder or other joints, except for up to 21 days postoperatively for the following surgical procedures: total knee arthroplasty, anterior cruciate ligament reconstruction, or open reduction and internal fixation of tibial plateau for distal femur fractures involving the knee joint.
- For ductal lavage of the mammary ducts.
- For extracorporeal shock wave treatment, also known as orthotripsy, using either a high-or low-dose protocol, for treatment of plantar fasciitis and all other musculoskeletal conditions.
- For orthoptic training.
- For thermal capsulorrhaphy as a treatment of joint instability, including but not limited to instability of shoulders, knees and elbows.
- For elective abortion, unless the life or health of the mother is endangered.
- For transcutaneous electrical nerve stimulator (TENS).
- For Inpatient drug and alcohol treatment that is not rendered in a Hospital, Psychiatric Hospital, Residential Treatment Center or other Plan-approved Provider.
- For massage therapy, including but not limited to effleurage, petrissage and/or tapotement.
- Which are not specifically named as Covered Services subject to any other specific Exclusions and limitations in this Contract.

We may, without waiving these Exclusions, elect to provide Benefits for care and services while awaiting the decision of whether or not the care and services fall within the Exclusions listed above. If it is later determined that the care and services are excluded from your coverage, we will be entitled to recover the amount we have allowed for Benefits under the Contract. You must provide to us all documents needed to enforce our rights under this provision.

General Provisions

This section tells:

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

ENTIRE CONTRACT; CHANGES

This Contract, with the application and the Identification Card, is the entire Contract between you and the Plan. No change in this Contract will be effective until approved by an authorized Plan officer. This approval must be noted o nor attached to this Contract. No agent or representative of the Plan other than a Plan officer may otherwise change this Contract or waive any of its provisions. All statements made by the Subscriber or by an individual Member shall, in the absence of fraud, be deemed representatives and not warranties.

BENEFITS TO WHICH YOU ARE ENTITLED

We provide only the Benefits specified in this Contract.

Only Subscribers are entitled to Benefits from us and they may not transfer their rights to Benefits to anyone else.

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

PRIOR APPROVAL

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

NOTICE AND PROPERLY FILED CLAIM

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

Your Properly Filed Claim must be furnished to the Plan within 90 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 you show that the claim was given as soon as reasonably possible.

PREMIUMS AND CONTRACT CHANGES

The amount of premium shall be the amount determined by the Plan for the Benefits of this Contract.

The Plan may change premiums upon 31 days' notice to the Member or as permitted by applicable law.

The Plan is hereby granted discretionary authority to determine, alter and interpret the provisions, language and Benefits set forth in this Contract or the payment of premiums therefore. Any changes in Benefits or premiums shall not affect any Subscriber during the coverage period for which premiums have been paid. Any increase in premiums shall be made only upon 31 days' notice to the Member prior to the effective date of the premium increase.

All premiums for coverage shall be paid to the Plan and shall be payable on or before each Member's Effective Date. All further premiums shall be due and payable in advance of and no later than the due date for the coverage period as stated in the periodic Member billing notice.

A Tobacco User may be subject to a premium variance of up to 1.5 times the rate applicable to those who are not Tobacco Users, to the extent permitted by applicable law, provided that the Plan will provide an opportunity to offset such premium variation through participation in a wellness program.

Premium rates are based upon the amount of taxes, fees, surcharges or other amounts currently in effect by various governmental agencies. If the amount of taxes, fees, surcharges or other amounts which the Plan is required to pay or remit are increased during the Policy Year, the Plan reserves the right, at its option, to charge Member for such amounts or adjust the premium rates to reflect such increase, on the effective date of such increase. Upon request, Member shall furnish to the Plan in a timely manner all information necessary for the calculation or administration of any such taxes, fees, surcharges or amounts.

Member is hereby notified that beginning in 2014, the Affordable Care Act (ACA) requires that covered entities providing health insurance ("health insurer") pay an annual fee to the federal government (the "Health Insurer Fee"). The amount of this fee for a Calendar Year will be determined by the federal government and involves a formula based in part on a health insurer's net premiums from the preceding Calendar Year. In addition, ACA provides for the establishment of temporary transitional reinsurance program(s) that will run from 2014 through 2016 and will be funded by reinsurance contributions ("Reinsurance Fee") from health insurance issuers and self-funded group health plans. Federal and state governments will provide information as to how the reinsurance fee is calculated. Beginning with your bill for January 1, 2014 coverage, your premium will be adjusted to reflect the effects of the Health Insurer Fees and the Reinsurance Fees.

GRACE PERIOD

A grace period of 31 days will be granted for the payment of each premium falling due after the first premium, during which grace period, the Contract shall continue in force. After a grace period of 31 days, coverage under this Contract will automatically terminate on the last day of the coverage period for which premiums have been paid.

PREMIUM REBATES, PREMIUM ABATEMENTS AND COST-SHARING

- Rebate. In the event federal or state law requires the Plan to rebate a portion of annual premiums paid, the Plan will directly provide any rebate owed Members or former Members to such persons in amounts as required by law.
- Abatement. The Plan may from time to time determine to abate (in whole or in part) the premium due under this Contract 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 Contract. An abatement for one

period shall not constitute a precedent or create an expectation or right as to any abatement in any future period(s).

- 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 Member or former Member (if applicable) 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 any Coinsurance amount, Copayment amounts and/or Deductibles under this Contract.

TIME LIMIT ON CERTAIN DEFENSES

After two years from the Effective Date of coverage for any Subscriber, no misstatements or omissions, except fraudulent misstatements or omissions, made in the application for coverage shall be used to void this Contract or to deny a claim for loss incurred after the expiration of such two-year period.

No claim for loss incurred after two years from the Effective Date of this Contract shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the Subscriber's Effective Date. However, this provision shall not apply to a disease or physical condition for which a fraudulent misstatement or omission was made by the Subscriber in his/her application for coverage.

LIMITATION OF ACTIONS

No legal action may be taken to recover Benefits within 60 days after a Properly Filed Claim has been made. No such action may be taken later than three years after expiration of the time within which a Properly Filed Claim is required by this Contract. In addition, the Subscriber must exhaust his/her appeal rights, as set forth in the "***Complaint/Appeal Procedure***" section of this Contract, before pursuing other legal remedies.

PAYMENT OF BENEFITS

You authorize us to make payments directly to Providers giving Covered Services for which we provide Benefits under the Contract. We also reserve the right to make payments directly to you.

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

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

Benefits under the Contract will be based upon the Allowable Charge (as we determine) for Covered Services. A Network Provider will accept the Allowable Charge as payment in full and will make no additional charge to you for Covered Services. **However, if you receive Covered Services from an Out-of-Network Provider, you may be responsible for amounts which exceed the Allowable Charge, in addition to any Deductible, Copayment and/or Coinsurance amounts which may apply.**

OUT-OF-AREA SERVICES

Blue Cross and Blue Shield of Oklahoma has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs." Whenever you obtain health care services outside of our service area, the claims for these services may be processed through one of these Inter-Plan Programs, which includes the BlueCard Program.

Typically, when accessing care outside our service area, you will obtain care from health care Providers that have a contractual agreement (i.e., are "participating or network Providers") with the local Blue Cross and/or

Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from non-participating or out-of-network health care Providers. Our payment practices in both instances are described below.

- **BlueCard® Program**

  Under the BlueCard® Program, when you access Covered Services within the geographic area served by a Host Blue, we will remain responsible for fulfilling our contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating health care Providers.

  Whenever you access Covered Services outside our service area and the claim is processed through the BlueCard Program, the amount you pay for Covered Services is calculated based on the lower of:

  – The billed charges for your Covered Services; or

  – The negotiated price that the Host Blue makes available to us.

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

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

  Federal law or the laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any Covered Services according to applicable law.

- **Non-Participating Health Care Providers Outside the Blue Cross and Blue Shield of Oklahoma Service Area**

  – **Subscriber Liability Calculation**

    When Covered Services are provided outside of our service area by non-participating health care Providers, the amount you pay for such services will generally be based on either the Host Blue's non-participating health care Provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating health care Provider bills and the payment we will make for the Covered Services as set forth in this paragraph.

    If you need Emergency Care, Blue Cross and Blue Shield of Oklahoma will cover you at the highest level that federal regulations allow. You will have to pay for any charges that exceed the Allowable Charge as well as for any Deductibles, Coinsurance, Copayments, and amounts that exceed any Benefit maximums.

  – **Exceptions**

    In certain situations, the Host Plan's pricing may be unavailable. In that event, we will calculate the pricing for your claim in accordance with the "Allowable Charge" provisions set forth in the "***Important Information***" and "***Definitions***" sections of your Contract. In these situations, you may be liable for the difference between the amount that the non-participating health care Provider bills and the payment we make for the Covered Services.

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

MEMBER DATA SHARING

You may, under certain circumstances, as specified below, apply for and obtain, subject to any applicable terms and conditions, replacement coverage. The replacement coverage will be that which is offered by Blue Cross and Blue Shield of Oklahoma, a division of Health Care Service Corporation, or, if you do not reside in the Blue Cross and Blue Shield of Oklahoma service area, by the Host Blue whose service area covers the geographic area in which you reside. The circumstances mentioned above may arise in various circumstances, such as from involuntary termination of your health coverage sponsored by the Member. As part of the overall plan of Benefits that Blue Cross and Blue Shield of Oklahoma offers to you, if you do not reside in the Blue Cross and Blue Shield of Oklahoma service area, Blue Cross and Blue Shield of Oklahoma may facilitate your right to apply for and obtain such replacement coverage, subject to applicable eligibility requirements, from the Host Blue in which you reside. To do this we may (1) communicate directly with you and/or (2) provide the Host Blue whose service area covers the geographic area in which you reside, with your personal information and may also provide other general information relating to your coverage under the Contract the Member has with Blue Cross and Blue Shield of Oklahoma to the extent reasonably necessary to enable the relevant Host Blue to offer you coverage continuity through replacement coverage.

DETERMINATION OF BENEFITS AND UTILIZATION REVIEW

The Plan, as claims administrator, is hereby granted discretionary authority to interpret the terms and conditions of the Contract and to determine its Benefits.

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

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

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

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

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

Failure of the Subscriber to comply with the Plan's request for medical records or medical evaluation may result in Benefits being partially or wholly denied.

SUBSCRIBER/PROVIDER RELATIONSHIP

The choice of a Provider is solely yours.

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

We do not furnish Covered Services but only provide Benefits for Covered Services you receive from Providers. We are not liable for any act or omission of any Provider. We have no responsibility for a Provider's failure or refusal to give Covered Services to you.

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

ACTUARIAL VALUE

The use of a metallic name in your ***Schedule of Benefits*** or Outline of Coverage, 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.

PHYSICAL EXAMINATION/AUTOPSY

The Plan, at its own expense, shall have the right and opportunity to examine the Subscriber when and as often as it may reasonably require during the pendency of a claim hereunder and to request an autopsy in case of death where it is not forbidden by law.

COORDINATION OF BENEFITS

All Benefits provided under the Contract are subject to this provision.

- **Definitions**

  In addition to the definitions of this Contract, the following definitions apply to this provision.

  "*Program*" means any arrangement providing health care Benefits or services through coverage under any tax supported or government program, including Medicare, except where state or federal law requires this Contract to reimburse for or to pay before the benefits of such tax supported or government program. However, in no event will the Benefits of this Contract paid because of such law exceed the lesser of the benefits required to be paid by such law and the Benefits available under this Contract in the absence of such tax supported or government program.

  "Program" shall be applied separately with respect to each arrangement for benefits or services and separately with respect to that portion of any arrangement which reserves the right to take the benefits or services of other Programs into consideration in determining its benefits and that portion which does not.

  "*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 Program covering the person for whom claim is made or service provided. When Benefits are provided in the form of services, the reasonable cash value of each service shall be deemed the Benefit.

- **Effect On Benefits**

  This provision will apply in determining the Benefits of this Contract for any Calendar Year if, for the Covered Services received during that period, the sum of the Benefits payable under this Contract and the Benefits payable under other Programs would exceed the Covered Services.

The Benefits payable under this Contract for Covered Services received during a Calendar Year will be reduced so that the sum of the reduced Benefits and the Benefits payable for Covered Services under other Programs does not exceed the Allowable Charge for Covered Services. Benefits payable under other Programs include the Benefits that would have been payable had claim been made.

The rule establishing the order of Benefits when a person receives Covered Services under any other Program is: The benefits of the other Program, including Medicare, will be determined before the Benefits of this Contract and the Benefits of this Contract will be reduced to the extent set forth in the paragraph above.

- **Facility of Payment**

  Whenever payments should have been made under this Contract in accordance with this provision, but the payments have been made under any other Program, the Plan has the right to pay to any organization that has made such payment any amount it determines to be warranted to satisfy the intent of this provision. Amounts so paid will be deemed to be Benefits paid under this Contract and, to the extent of the payments for Covered Services, the Plan will be fully discharged from liability under this Contract.

- **Right of Recovery**

  Whenever payments have been made by the Plan for Covered Services in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, irrespective of to whom paid, the Plan will have the right to recover the excess from among the following, as the Plan will determine: any person to or for whom such payments were made, any insurance company, or any other organization.

  The Member, personally and on behalf of family Subscribers shall, upon request, execute and deliver such documents as may be required and do whatever else is necessary to secure the Plan's rights to recover the excess payments.

PLAN'S RIGHT OF RECOUPMENT

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

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

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

LIMITATIONS ON PLAN'S RIGHT OF RECOUPMENT/RECOVERY

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

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

PLAN/ASSOCIATION RELATIONSHIP

Each Member hereby expressly acknowledges his/her understanding that the Contract constitutes a contract solely between the Member and Blue Cross and Blue Shield of Oklahoma. Blue Cross and Blue Shield of Oklahoma is a division of Health Care Service Corporation, a Mutual Legal Reserve Company, an independent licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"). The license from the Association permits Blue Cross and Blue Shield of Oklahoma to use the Blue Cross and Blue Shield Service Marks in the State of Oklahoma. Blue Cross and Blue Shield of Oklahoma is not contracting as the agent of the Association. It is further understood that the Member has not entered into the contract based upon representations by any person other than Blue Cross and Blue Shield of Oklahoma. No person, entity, or organization other than Blue Cross and Blue Shield of Oklahoma shall be held accountable or liable to the Member for any of Blue Cross and Blue Shield of Oklahoma's obligations created under this Contract. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield of Oklahoma other than those obligations created under other provisions of this Contract.

THE PLAN'S SEPARATE FINANCIAL ARRANGEMENTS WITH PRESCRIPTION DRUG PROVIDERS

The Plan hereby informs you 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 Contract, 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 you. Actual discounts used to calculate your 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.

You understand that Blue Cross and Blue Shield may receive such discounts. You are not entitled to receive any portion of any such discounts. The drug fees/discounts that Blue Cross and Blue Shield has negotiated with Prime Therapeutics LLC ("Prime") through the Pharmacy Benefit Management ("PBM") Agreement, will be used to calculate your 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 you as described above).

For the mail 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 you as expenses, or accrue to the benefit of you, unless otherwise specifically set forth in this Contract. 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 you 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 Contract. 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. You are not entitled to receive any portion of any such rebates as they are calculated into the pricing of the product.

NOTICE OF ANNUAL MEETING

You are hereby notified that you are a Member of Blue Cross and Blue Shield of Oklahoma, a division of Health Care Service Corporation, a Mutual Legal Reserve Company ("HCSC"), and you are entitled to vote in person, or by proxy, at all meetings of HCSC. The annual meeting is held at our principal office at 300 East Randolph, Chicago, Illinois each year on the last Tuesday in October at 12:30 p.m.

The term "Member" as used above refers only to the person to whom this Contract is issued. It does not include any other family members covered under family coverage unless such family member is acting on your behalf.

Subscriber Rights

Blue Cross and Blue Shield of Oklahoma is happy to be able to serve you and provide the quality health care Benefits you need and deserve. As with any health insurance plan, you, and each of your covered Dependents, have certain rights.

You have the right to:

- confidentiality of health information;
- receive Medically Necessary and appropriate care and service as defined in this Contract;
- receive courteous and respectful care and services from Blue Cross and Blue Shield of Oklahoma employees and Network Providers;
- receive information in clear and understandable terms;
- participate with your Provider in decision-making about your health care treatment;
- refuse treatment;
- file complaints when dissatisfied with the care and treatment received;
- appeal an Adverse Benefit Determination or a decision regarding a Preauthorization request;
- designate an authorized representative to act on your behalf in pursuing a Benefit claim or appeal of an Adverse Benefit Determination.

Claims Filing Procedures

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

PARTICIPATING PROVIDERS

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

REMEMBER...

To receive the maximum Benefits under this Contract for your Covered Services, you must receive treatment from Network Providers.

PRESCRIPTION DRUG CLAIMS

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

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

HOSPITAL CLAIMS

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

AMBULATORY SURGICAL FACILITY AND OTHER FACILITY CLAIMS

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

PHYSICIAN AND OTHER PROVIDER CLAIMS

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

MEMBER-FILED CLAIMS

When you must file a claim yourself, you may obtain claim forms by contacting the Plan. Be sure to fill out the claim form completely, sign it, and attach the Provider's itemized statement. Send the completed form to:

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

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

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

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

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

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

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

Remember, we must receive your claims for Covered Services within 90 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 you or your Provider, a Benefit determination will be made within 30 days. This period may be extended one time for up to 15 additional days, if the Plan determines that additional time is necessary due to matters beyond our control.

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

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

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

DIRECT CLAIMS LINE

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

Complaint/Appeal Procedure

Blue Cross and Blue Shield of Oklahoma has established the following process to review your dissatisfactions, complaints, and/or appeals. If you have designated an authorized representative, that person may act on your behalf in the appeal process.

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

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

CLAIM DETERMINATIONS

When the Plan receives a Properly Filed Claim, it has authority and discretion under this Contract to interpret and determine Benefits in accordance with the Contract provisions.

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

IF A CLAIM IS DENIED OR NOT PAID IN FULL

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

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

TIMING OF REQUIRED NOTICES AND EXTENSIONS

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

URGENT CARE CLAIMS*

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

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

PRE-SERVICE CLAIMS

Type of Notice or Extension	Timing
If your claim is filed improperly, we must notify you within:	**5 days**
If your claim is incomplete, we must notify you within:	**15 days**
If you are notified that your claim is incomplete, you must then provide completed claim information to us within:	**45 days after receiving notice**
If we deny your initial claim, we must notify you of the denial:	
if the initial claim is complete within:	**15 days***
after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**

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

POST-SERVICE CLAIMS

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

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

CLAIM APPEAL PROCEDURES

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

  An "**Adverse Benefit Determination**" means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Benefit, including any such denial, reduction, termination, or failure to provide or make payment for, a Benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which Benefits are otherwise provided because it is determined to be Experimental, Investigational or Unproven or not Medically Necessary or appropriate. If an ongoing course of treatment had been approved by the Plan and the Plan reduces or terminates such treatment (other than by amendment or termination of this Contract) 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 is defined as a cancellation or discontinuance of coverage that has a retroactive effect. It does not include a termination of coverage for reasons related to non–payment of premium.

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

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

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

  Upon receipt of an expedited pre-service or concurrent clinical appeal, we will notify the party filing the appeal, as soon as possible, but no more than 24 hours after submission of the appeal, of all information needed to review the appeal. Additional information must be submitted within 24 hours of request. The Plan shall render a determination on the appeal as soon as possible (taking into account medical exigencies) but

no later than 72 hours after it receives the initial request, or within 48 hours after it receives the missing information (if the initial request is incomplete).

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

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

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

  If you believe we incorrectly denied all or part of your Benefits, you may have your claim reviewed. We will review its decision in accordance with the following procedures:

  – Within 180 days after you receive notice of an Adverse Benefit Determination, you may call or write to our Administrative Office. We will need to know the reasons why you do not agree with the Adverse Benefit Determination. Send your request to:

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

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

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

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

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

- ***Timing of Appeal Determinations***

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

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

- ***Notice of Appeal Determination***

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

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

  - A reason for the determination;
  - A reference to the Benefit provisions on which the determination is based, and the contractual, administrative or protocol for the determination;
  - Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care Provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
  - An explanation of our external review processes (and how to initiate an external review);
  - In certain situations, a statement in non-English language(s) that the written notice of the claim denial and certain other Benefit information may be available (upon request) in such non-English language(s);
  - In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by us;
  - The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for Benefits;
  - Any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
  - An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;
  - A description of the standard that was used in denying the claim and a discussion of the decision; and
  - Contact information for applicable office of health insurance consumer assistance or ombudsman.

EXTERNAL REVIEW RIGHTS

If you receive an Adverse Benefit Determination, you may have a right to have our decision reviewed by independent health care professionals who have no association with ***us if our decision involved making a judgment as to the Medical Necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment.*** The request for an external review by an Independent Review Organization (IRO) must be submitted within four months after you receive notice of the internal appeal determination. You or your authorized representative may file a request for external review by completing the required forms and submitting them directly to the address noted below. We will also provide the forms to you upon request.

Oklahoma Insurance Department
P.O. Box 53408
Oklahoma City, OK 73152-3408
1-800-522-0071 (Oklahoma only)
405-521-2991

For a standard external review, a decision will be made within **45 days** of receiving your request. If you have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed, you may be entitled to request an **expedited external review** of our denial. If our denial to provide or pay for a health care service or course of treatment is based on a determination that the service or treatment is Experimental, Investigational or Unproven, you also may be entitled to file a request for external review of our denial.

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

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

Oklahoma Insurance Department
3625 NW 56th Street
Oklahoma City, OK 73112-4511
http://www.ok.gov/oid/Consumer/index.html
Telephone: 1-800-522-0071 or 405-521-2828

Definitions

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

ADVANCE PREMIUM TAX CREDIT

The advance payment of a refundable premium tax credit an eligible individual may receive for taxable years ending after December 31, 2013, as provided for under applicable law where the advanced payment is used to offset all or a portion of the premium for coverage obtained by that individual through the Exchange.

ALLOWABLE CHARGE

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

- ***For Comprehensive Health Care Services:***
  - **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 the "***Important Information***" section.
- ***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" will be determined by the Blue Cross and **Blue Shield Plan (Host Plan) servicing the area. Benefits will be based upon the Provider payment arrangements in effect between the Provider** and **the on-site Plan. For Out-of-Network Provider services, the Allowable Charge will be based upon the amount the Host Plan uses for their own local members that obtain services from local non-contracting Providers.**

AMBULATORY SURGICAL FACILITY

A Provider with an organized staff of Physicians which:

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

BENEFIT PERIOD

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

BENEFITS

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

BLUECARD PROVIDER

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

CALENDAR YEAR

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

COINSURANCE

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

CONTRACT

This agreement including your application and any amendment between you and us.

COPAYMENT

A fixed dollar amount required to be paid by or on behalf of a Subscriber in connection with the delivery of some Covered Services. Refer to the ***Schedule of Benefits for Comprehensive Health Care Services*** for any Copayments applicable to your coverage.

COVERED DRUG

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

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

COVERED SERVICE

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

CREDITABLE COVERAGE

Coverage of an individual from a wide range of sources, including group health plans, Individual Health Insurance Coverage, COBRA continuation coverage, Medicare, and Medicaid.

CUSTODIAL CARE

Aid to patients who need help with daily tasks like eating, dressing and walking. Custodial Care does not directly treat an injury or illness.

DEDUCTIBLE

A specified amount of Covered Services that you must incur before Benefits are available. Refer to the ***Schedule of Benefits for Comprehensive Health Care Services*** for any Deductibles applicable to your coverage.

DEPENDENT

A Subscriber other than the Member as shown in the ***Eligibility, Enrollment, Changes*** and ***Termination*** section.

DIAGNOSTIC SERVICE

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

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

DOMESTIC PARTNER

A companion of the same sex or opposite sex with whom the Member has entered into a Domestic Partnership.

DOMESTIC PARTNERSHIP

A same-sex or opposite sex couple in a committed relationship, similar to a marriage, but without an official marriage license.

DURABLE MEDICAL EQUIPMENT

Equipment which meets the following criteria:

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

EFFECTIVE DATE

The date when your coverage begins.

ELIGIBLE PERSON

A person entitled to apply to be a Member as specified in the ***Eligibility, Enrollment, Changes*** and ***Termination*** section.

EMERGENCY CARE

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

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

EXCHANGE (ALSO KNOWN AS "HEALTH INSURANCE MARKETPLACE")

A governmental agency or non-profit entity that meets the applicable Exchange standards, and other related standards established under the Affordable Care Act (ACA), and makes Qualified Health Plans (QHP) available to Qualified Individuals and qualified employers. Unless otherwise identified, this term refers to State Exchanges, regional Exchanges, subsidiary Exchanges, and a Federally-facilitated Exchange on which Blue Cross and Blue Shield of Oklahoma offers this QHP.

EXPERIMENTAL/INVESTIGATIONAL/UNPROVEN

A drug, device, biological product, or medical treatment or procedure is Experimental, Investigational, 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.

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 Covered Drugs, the Plan uses the generic/brand status assigned by a nationally recognized provider of drug product database information. A list of high-cost and low-cost Generic Drugs is available on the Plan's Web site at www.bcbsok.com. You may also contact a Customer Service Representative for more information.

GENERICS PLUS DRUG LIST

A sample listing of the most commonly prescribed medications available in the Generic Drug and Preferred Brand Drug categories. This list is developed using monographs written by the American Medical Association, Academy of Managed Care Pharmacies, and other pharmacy and medical related organizations, describing clinical outcomes, drug efficacy, and side effect profiles.

HOME HEALTH CARE AGENCY

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

HOSPICE

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

HOSPITAL

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

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

HOSPITAL ADMISSION

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

IDENTIFICATION CARD

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

INDIVIDUAL HEALTH INSURANCE COVERAGE

Health insurance coverage offered to individuals in the individual market, but not including short-term, limited-duration insurance. Individual Health Insurance Coverage can include Dependent coverage.

INPATIENT

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

INTENSIVE OUTPATIENT TREATMENT

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

LICENSED PRACTICAL OR VOCATIONAL NURSE (LPN OR LVN)

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

MAINTENANCE PRESCRIPTION DRUG

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

MATERNITY SERVICES

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

MEDICAL CARE

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

MEDICALLY NECESSARY (OR MEDICAL NECESSITY)

Health care services that 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.

MEMBER

An Eligible Person who has enrolled for coverage.

MENTAL ILLNESS

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

MINIMUM ESSENTIAL COVERAGE

Health insurance coverage that is recognized as coverage that meets substantially all requirements under applicable law pertaining to adequate individual, group or government health insurance coverage. Loss of Minimum Essential Coverage does not include termination of coverage for failure to pay premiums or as a result of a rescission. For additional information on whether particular coverage is recognized as Minimum Essential Coverage, please call the Customer Service number shown on the back of your Identification Card or visit www.cms.gov.

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.

NETWORK SERVICE AREA

The geographic area designated by the Plan, within which the Benefits of this Contract are available to Subscribers. A Subscriber may call the Customer Service Department at the number shown on the Identification card to determine if he or she is in the Network Service Area or visit the Web site at www.bcbsok.com.

NON-PREFERRED BRAND DRUG

A name-brand Prescription Drug which has not been designated by the Plan as a Preferred Brand Drug and which does not appear on the Generics Plus Drug List.

OKLAHOMA RESIDENT

A person domiciled in the state of Oklahoma. "Domicile" is the place established as your true, fixed and permanent home. It is the place you intend to return to whenever you are away (as on vacation abroad, business assignment, education leave or military assignment). A domicile, once established, remains until a new one is adopted.

ORTHOGNATHIC SURGERY

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

Out-of-Network Pharmacy

A Pharmacy that has not entered into a Participating Pharmacy Agreement with the 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 Limit

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

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

Outpatient

A Subscriber who receives services or supplies while not an Inpatient.

Participating Pharmacy

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

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

Participating Specialty Pharmacy

A Pharmacy that has entered into an agreement to be a part of the Plan's Specialty Pharmacy Network.

Pharmacy

A person, firm or corporation duly authorized by state law to dispense Prescription Drugs.

Physician

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

Placement for Adoption (or Placed for Adoption)

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

Plan

Blue Cross and Blue Shield of Oklahoma.

POLICY YEAR

The 12-month period beginning January 1 each year.

PREAUTHORIZATION

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

Preauthorization does not guarantee that the care and services you receive are eligible for Benefits under the Contract. At the time your claims are submitted, they will be reviewed in accordance with the terms of the Contract.

PREFERRED BRAND DRUG

A brand-name drug which has been designated by the Plan to be a part of its Preferred Brand Prescription Drug Program and which appears on the Generics Plus Preferred Drug List .

PRESCRIPTION DRUG

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

PRESCRIPTION ORDER

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

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, as set forth in the ***Comprehensive Health Care Services*** section.

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

PROPERLY FILED CLAIM

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

PROVIDER

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

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.

QUALIFIED HEALTH PLAN (QHP)

A health care benefit program that has in effect a certification that it meets the applicable standards issued or recognized by the Exchange through which such program is offered.

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.

RETAIL HEALTH CLINIC

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

RETAIL PHARMACY VACCINATION NETWORK

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

ROUTINE NURSERY CARE

Ordinary Hospital nursery care of the newborn Subscriber.

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, substance abuse, 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 that are high cost and generally prescribed for use in limited patient populations or indications. These drugs are typically injected, but may also include high cost oral medications. In addition, patient support and/or education and special dispensing or delivery may be required for these drugs; therefore,

they are difficult to obtain via traditional pharmacy channels. A considerable portion of the use and costs are frequently generated through office-based medical claims and may require complex reimbursement procedures. The list of Specialty Drugs is subject to change. To determine which drugs are Specialty Drugs, You should contact your Pharmacy, refer to the Web site at www.bcbsok.com or call the Customer Service toll-free number on your Identification Card.

SPECIALTY PHARMACY NETWORK

A limited network of Participating Pharmacies that provide the following services to Subscribers:

- access to high-cost medications that are used in limited populations;
- special dispensing, delivery and patient clinical support;
- guidance through complex reimbursement procedures for Specialty Pharmacy Drugs.

SUBSCRIBER

The Member and each of his/her Dependents (if any) enrolled under this Contract.

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 your recovery from an illness or injury:

- **Radiation Therapy** – the treatment of disease by x-ray, radium, or radioactive isotopes.
- **Chemotherapy** – the treatment of malignant disease by chemical or biological antineoplastic agents, but not including High-Dose Chemotherapy. High-Dose Chemotherapy is specifically addressed in certain sections under "Human Organ, Tissue and Bone Marrow Transplant Services."
- **Respiratory Therapy** – introduction of dry or moist gases into the lungs for treatment purposes.
- **Dialysis Treatment** – the treatment of an acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body to include hemodialysis or peritoneal dialysis.
- **Physical Therapy** – the treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles, and devices to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of body part.
- **Speech Therapy** – treatment for the correction of a speech impairment resulting from disease, Surgery, injury, congenital and developmental anomalies, or previous therapeutic processes.
- **Occupational Therapy** – treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role.

TOBACCO USER

A person who is permitted under state and federal law to legally use tobacco, with tobacco use (other than religious or ceremonial use of Tobacco) on average four or more times per week that last occurred within the

past six months (or such other meaning required or permitted by applicable law). Tobacco includes, but is not limited to: cigars, smokeless tobacco, snuff, electronic cigarettes, etc. For additional information, please call the number on the back of your ID card or visit our Web site at www.bcbsok.com.

TOTAL DISABILITY (OR TOTALLY DISABLED)

A condition resulting from disease or injury in which, as certified by a Physician:

- The Subscriber is unable to perform the substantial duties of any occupation or business for which he/she is qualified and the Subscriber is not in fact engaged in any occupation for wages or profit; or
- If the Subscriber does not usually work for wages or profit, the Subscriber cannot do the normal activities of a person of the same age and sex.

The Plan reserves the right to review a Physician's certificate of disability and/or request medical records and/or require a medical examination by an independent Physician to verify disability at the Subscriber's expense. The Plan will make the final determination as to whether the Subscriber is Totally Disabled.

BlueCross BlueShield of Oklahoma

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

PEDIATRIC VISION CARE ADDENDUM

The Contract to which this Addendum is attached and becomes a part is hereby amended as stated below.

This *Pediatric Vision Care Addendum* provides information about coverage for the routine vision care services outlined below. Services that are covered under your ***Comprehensive Health Care Services*** Benefits are not covered under this *Pediatric Vision Care Addendum*. All provisions in your Contract for ***Comprehensive Health Care Services*** Benefits apply to this *Pediatric Vision Care Addendum* unless specifically indicated otherwise below.

This vision care coverage allows Subscribers 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 your ***Comprehensive Health Care Services*** Benefits, at the most affordable cost, through network services. You also have the flexibility to visit an Out-of-Network Provider, with a reduction in Benefits.

For a list of Vision Care Network Providers, please contact a Customer Service Representative at the number shown on the back of your Identification Card, or visit the Plan's Web site at www.bcbsok.com.

A. DEFINITIONS

The following definitions are added to the ***Definitions*** section of your Contract:

- **Provider** – A licensed ophthalmologist or optometrist operating within the scope of his or her license, or a dispensing optician. A Vision Care Network Provider is a Provider who has contracted with the Plan or its designated vision care plan administrator to provide services under this Pediatric Vision Care Addendum.

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

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

B. ELIGIBILITY

Children who are covered under the Blue Cross and Blue Shield of Oklahoma Individual PPO Contract, up to age 19, are eligible for coverage under this *Pediatric Vision Care Addendum.* NOTE: Once coverage is lost under the Individual PPO Contract, all Benefits cease under this *Pediatric Vision Care Addendum.* Extension of Benefits due to disability, state or federal continuation coverage, and conversion option privileges are **not** available under this *Pediatric Vision Care Addendum.*

C. SCHEDULE OF BENEFITS

The following ***Schedule of Benefits*** is added to your Contract:

SCHEDULE OF BENEFITS FOR PEDIATRIC VISION CARE SERVICES

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

Pediatric Vision Care Benefits		
Pediatric Vision Care Services	**In-Network Subscriber Cost**	**Out-of-Network Subscriber Cost**
Exam (with dilation as necessary):	No Deductible or Coinsurance for routine exams	The Plan pays up to $30, not to exceed the retail cost
Frames:	The following amounts apply after the Subscriber's Deductible* has been met:	The following amounts apply after the Subscriber's Deductible* has been met:
"Collection" Frames Non-Collection Frames Note: "Collection" frames with retail values up to $225 are available at most Network Providers. Retail chain Providers typically do not display the "Collection," but are required to maintain a comparable selection of frames.	20% of Allowable Charge 20% of Allowable Charge	40% of Allowable Charge 40% of Allowable Charge
Frequency: Examination, Lenses, or Contact Lenses Frames	Once every Calendar Year Once every Calendar Year	
Standard Plastic, Glass, or Poly Spectacle Lenses:	The following amounts apply after the Subscriber's Deductible* has been met:	The following amounts apply after the Subscriber's Deductible* has been met:
Single Vision Lined Bifocal Lined Trifocal Lenticular Note: All lenses include scratch resistant coating with no additional charge. There may be an additional charge at certain retail outlets. Call a Customer Service Representative or visit our Web site at www.bcbsok.com for additional information.	20% of Allowable Charge 20% of Allowable Charge 20% of Allowable Charge 20% of Allowable Charge	40% of Allowable Charge 40% of Allowable Charge 40% of Allowable Charge 40% of Allowable Charge

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Pediatric Vision Care Services	In-Network Subscriber Cost	Out-of-Network Subscriber Cost
Lens Options:	The amounts below are in addition to lens prices above:	Not Covered
Ultraviolet Protective Coating	$0	
Polycarbonate Lenses	$0	
Blended Segment Lenses	$20	
Intermediate vision Lenses	$30	
Standard Progressives	$0	
Premium Progressive (Varilux®, etc.)	$90	
Photochromic Glass Lenses	$20	
Plastic Photosensitive Lenses (Transitions®)	$0	
Polarized Lenses	$75	
Standard Anti-Reflective (AR) Coating	$35	
Premium AR Coating	$48	
Ultra AR Coating	$60	
High Index Lenses	$55	
Progressive Lens Options – Subscribers may receive a discount on additional progressive lens options:		
Select Progressive Lenses	$70	
Ultra Progressive Lenses	$195	
Contact Lenses: covered once every Calendar Year – in lieu of eyeglasses	The following amounts apply after the Subscriber's Deductible* has been met:	The following amounts apply after the Subscriber's Deductible* has been met:
Elective	20% of Allowable Charge	40% of Allowable Charge
Medically Necessary contact lenses – Preauthorization is required	20% of Allowable Charge	40% of Allowable Charge
Note: In some instances, Network Providers may charge separately for the evaluation, fitting, or follow-up care relating to contact lenses.		
Note: Additional Benefits may be available from Network Providers except certain retail outlets. Call a Customer Service Representative or visit our Web site at www.bcbsok.com for additional information.		
Routine eye exams do not include professional services for contact lens evaluations. Any applicable fees are the responsibility of the Subscriber.		

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Value-added features: **Laser vision correction:** You will receive a discount for traditional LASIK and custom LASIK from Vision Care Network Physicians and affiliated laser centers. You must obtain Preauthorization for this service. *Prices/discounts may vary by state and are subject to change without notice.* **Mail-order contact lens replacement:** Lens 1-2-3® Program (visit the Lens 1-2-3 Web site: www.lens123.com).
Additional Benefits
Medically Necessary contact lenses: Contact lenses may be determined to be Medically Necessary and appropriate in the treatment of Subscribers 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. Network Providers will obtain the necessary Preauthorization for these services.
Low Vision: Low vision is a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in low vision care can evaluate and prescribe optical devices, and provide training and instruction to maximize the remaining usable vision for our Subscribers with low vision. After Preauthorization, covered low vision services (both In- and Out-of-Network) will include one comprehensive low vision evaluation every 5 years, with a maximum charge of $300; maximum low vision aid allowance of $600 with a lifetime maximum of $1,200 for items such as high-power spectacles, magnifiers and telescopes; and follow-up care – four visits in any five-year period, with a maximum charge of $100 each visit. Network Providers will obtain the necessary Preauthorization for these services.
Warranty: Warranty limitations may apply to Provider or retailer supplied frames and/or eyeglass lenses. Please ask your Provider for details of the warranty that is available to you.

* Benefits are subject to the Benefit Period Deductible amounts shown in your ***Schedule of Benefits for Comprehensive Health Care Services.***

D. EXCLUSIONS

In addition to the ***Exclusions*** listed in your Contract, 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 your failure to comply with professionally prescribed treatment;
- telephone consultations;
- any services that are strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
- services or materials provided as a result of intentionally self-inflicted injury or illness;
- services or materials provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
- office infection control charges;
- charges for copies of your records, charts, or any costs associated with forwarding/mailing copies of your records or charts;
- state or territorial taxes on vision services performed;

- medical treatment of eye disease or injury;
- visual therapy;
- special lens designs or coatings other than those described in this Addendum;
- replacement of lost/stolen eyewear;
- non-prescription (Plano) lenses;
- two pairs of eyeglasses in lieu of bifocals;
- services not performed by licensed personnel;
- prosthetic devices and services;
- insurance of contact lenses;
- professional services you receive from immediate relatives or household members, such as a spouse, parent, child, brother or sister, by blood, marriage or adoption;
- services covered under your ***Comprehensive Health Care Services*** Benefits.

E. **HOW YOUR PEDIATRIC VISION CARE BENEFITS WORK**

Under this coverage, you 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, you must purchase them from a Vision Care Network Provider.

To locate a Network Provider for Pediatric Vision Care Benefits, visit our Web site at **www.bcbsok.com**, or call the Customer Service number shown on your Identification Card to obtain a list of the pediatric Vision Care Network Providers nearest you.

If you obtain eyeglasses or contacts from an Out-of-Network Provider, you must pay the Provider in full and submit a claim for reimbursement (see ***Claims Filing Procedures*** section in your Contract for more information).

You may receive your 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 you seek contact lenses from a Provider other than the one who performed your eye examination.

Fees charged for services other than a covered vision examination or covered Vision Materials, and amounts in excess of those payable under this *Pediatric Vision Care Addendum,* must be paid in full by you to the Provider, whether or not the Provider participates in the vision care network. Benefits under this *Pediatric Vision Care Addendum* 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 your right to appeal a claim determination, refer to the ***Complaint/Appeal Procedure*** section of your Contract.

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

Jeffrey R Tibbauer

Blue Cross and Blue Shield of Oklahoma

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NOTICE OF PROTECTION PROVIDED BY OKLAHOMA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary of the Oklahoma Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Oklahoma law, which determines who and what is covered and the amounts of coverage. The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Oklahoma law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values
- Health Insurance
  - $500,000 in hospital, medical and surgical insurance benefits
  - $300,000 in disability income insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits
- Annuities
  - $300,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000, except that with regard to hospital, medical and surgical insurance benefits, the maximum amount that will be paid is $500,000.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Oklahoma law.

To learn more about the above protections, please visit the Association's website at www.oklifega.org, or contact:

Oklahoma Life & Health Insurance Guaranty Association
201 Robert S. Kerr, Suite 600
Oklahoma City, OK 73102
Phone: (405) 272-9221

Oklahoma Department of Insurance
3625 NW 56th Street, Suite 100
Oklahoma City, OK 73112
1-800-522-0071 or (405) 521-2828

Insurance companies and agents are not allowed by Oklahoma law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Oklahoma law, then Oklahoma law will control.

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1400 South Boston
P. O. Box 3283
Tulsa, OK 74102-3283
1-866-520-2507

Blue Preferred Gold PPO℠ 007
Blue Preferred PPO℠ Network
Schedule of Benefits for Comprehensive Health Care Services

This schedule shows the Deductibles, Copayments and/or Coinsurance amounts that apply to Covered Services described in the ***Comprehensive Health Care Services*** section of your Contract. Deductibles, Copayments, Coinsurance amounts and Out-of-Pocket Limits may be subject to change or increase as permitted by applicable law. **Please note that services must be Medically Necessary, as determined by the Plan, in order to be covered.**

BENEFIT PERIOD/POLICY YEAR	Calendar Year
NETWORK PROVIDERS	To receive maximum Benefits under your Contract, you must receive services from Blue Preferred Providers in Oklahoma or BlueCard Providers outside the state of Oklahoma. Refer to www.bcbsok.com or call a Customer Service Representative at the number shown on your Identification Card to find a Network Provider near you.
OFFICE VISIT COPAYMENTS	The following Copayments will apply: • $30 for each visit to a Network Provider's office or Retail Health Clinic. • $30 for each visit to a Network Provider's office for Psychiatric Care Services. • $50 for each visit to a Network Specialist Physician's office. The Copayment applies to charges which are billed as part of the office visit, except for: • Preventive Care Services received from a Network Provider; • Annual mammography screening; • Covered childhood immunizations (for Subscribers under age 19); • Surgical services; • Physical Therapy, Occupational Therapy and Speech Therapy. **Copayments do not apply to services received from Out-of-Network Providers.**
DEDUCTIBLES	
Emergency Room Deductible	$400 for each visit to a Hospital emergency room. This Deductible is waived if you are admitted to the Hospital through the emergency room visit.
Outpatient Surgery Deductible	• $150 for each visit to a Network Outpatient facility for Surgery. This Deductible applies to surgical procedures received in a Hospital Outpatient department or Ambulatory Surgical Facility. • $250 for each visit to an Out-of-Network Outpatient facility for Surgery. This Deductible applies to surgical procedures received in an Out-of-Network Hospital Outpatient department or Ambulatory Surgical Facility.
Hospital Admission Deductible	• $200 for each admission to a Network Hospital. • $300 for each Out-of-Network Hospital Admission.

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Benefit Period Deductible	• **Network Provider Services** – $1,000 per Benefit Period per Subscriber, or $3,000 for all covered family members combined. • **Out-of-Network Provider Services** – $2,000 per Benefit Period per Subscriber, or $6,000 for all covered family members combined. Deductible amounts for Network Provider Services and Out-of-Network Provider Services ***do not*** cross-apply. The Benefit Period Deductible is in addition to the Emergency Room Deductible, Outpatient Surgery Deductible and Hospital Admission Deductible described above. The Benefit Period Deductible applies to all Covered Services, except: • Ambulance Services; • Network Physician services that are subject to the office visit Copayment. • Preventive Care Services received from a Network Provider. Preventive Care Services received from an Out-of-Network Provider are subject to Deductible, except for: – Annual routine gynecological/obstetrical examination and Pap smear; – Annual mammography screening; – Annual prostate cancer screening; – Covered childhood immunizations (for Subscribers under age 19); – Any other state or federally mandated Benefits which stipulate a Deductible may not be required.
OUT–OF–POCKET LIMIT	• **Network Provider Services** – $3,000 per Subscriber, or $9,000 for all covered family members combined. When this limit has been paid (including any Copayment and/or Deductible amounts) for Covered Services provided by Network Providers during a Benefit Period, the amount of Allowable Charges covered by the Plan for such Subscriber will increase to 100% during the remainder of the Benefit Period for Covered Services received from Network Providers. • **Out-of-Network Provider Services** – $6,000 per Subscriber, or $18,000 for all covered family members combined. When this limit has been paid (including any Deductible amounts) for Covered Services provided by Out-of-Network Providers during a Benefit Period, the amount of Allowable Charges covered by the Plan will increase to 100% during the remainder of the Benefit Period for Out-of-Network Provider services. Out-of-Pocket Limits for Network Provider Services and Out-of-Network Provider Services ***do not*** cross-apply. This Out-of- Pocket Limit does not include any of the following: • Services, supplies or charges limited or excluded by this Contract; • Expenses not covered because a Benefit maximum has been reached; • Any penalty incurred due to your failure to follow the Plan's requirements for Preauthorization, as set forth in the Contract.
BENEFIT PERCENTAGE AMOUNT	The following chart shows the percentage of Allowable Charges covered by this Contract through payments and/or contractual arrangements with Providers. These percentages apply only after your Deductibles and/or Copayment amounts have been satisfied. **NOTE: Any services classified as "Preventive Care Services" are paid at 100% of the Allowable Charge and are not subject to Copayments, Deductibles and/or Coinsurance, provided such services are received from Network Providers.**

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COVERED SERVICES (Subject to the *Comprehensive Health Care Services* section)		
	BENEFIT PERCENTAGE OF ALLOWABLE CHARGES PAID BY THE PLAN	
	Network Provider Services	Out-of-Network Provider Services
PREVENTIVE CARE SERVICES		
Annual Mammography Screening	100%	100%
Covered Childhood Immunizations	100%	100%
All Other Covered Preventive Care Services	100%	70%
EMERGENCY CARE SERVICES	80%	80%
THE FOLLOWING BENEFIT PERCENTAGES APPLY TO SERVICES THAT ARE NOT CLASSIFIED AS PREVENTIVE CARE SERVICES OR EMERGENCY CARE SERVICES, AS DETERMINED BY THE PLAN		
HOSPITAL SERVICES[1]	80%	60%
SURGICAL/MEDICAL SERVICES		
Physician's Office Visit	100%[2]	70%
Retail Health Clinic Visit	100%[2]	70%
All Other Covered Surgical/Medical Services	80%	60%
OUTPATIENT DIAGNOSTIC SERVICES	80%	60%
OUTPATIENT THERAPY SERVICES Maximum of 25 Outpatient visits for Physical Therapy, Occupational Therapy and Speech Therapy (combined) per Benefit Period	80%	60%
MATERNITY SERVICES	80%	60%
MASTECTOMY AND RECONSTRUCTIVE SURGICAL SERVICES	80%	60%
HUMAN ORGAN, TISSUE AND BONE MARROW TRANSPLANT SERVICES[3]	80%	60%
AMBULATORY SURGICAL FACILITY SERVICES	80%	60%
SERVICES RELATED TO TREATMENT OF AUTISM AND AUTISM SPECTRUM DISORDERS Physical Therapy, Occupational Therapy and Speech Therapy limited to a combined maximum of 390 visits per Benefit Period for Subscribers under age six[4]	80%	60%

[1] *Inpatient Hospital Services are subject to Preauthorization approval from the Plan. See the Contract for details regarding "Preauthorization" requirements.*

[2] *Applicable only to Covered Services which are subject to the office visit Copayment. For services which are not subject to the office visit Copayment, this percentage amount is reduced to 80% of Allowable Charges after satisfaction of the Deductible.*

[3] *Subject to Preauthorization approval from the Plan. See the Contract for details regarding "Preauthorization" requirements.*

[4] *Refer to "Outpatient Therapy Services" for Physical Therapy, Occupational Therapy and Speech Therapy visits applicable to Subscribers age six and older.*

COVERED SERVICES (Subject to the *Comprehensive Health Care Services* section)		
	BENEFIT PERCENTAGE OF ALLOWABLE CHARGES PAID BY THE PLAN	
	Network Provider Services	Out-of-Network Provider Services
PSYCHIATRIC CARE SERVICES	80%	60%
AMBULANCE SERVICES	80%	80%
PRIVATE DUTY NURSING SERVICES[1] 85 visit maximum per Benefit Period	80%	60%
REHABILITATION CARE[1] 30-day maximum per Benefit Period	80%	60%
SKILLED NURSING FACILITY SERVICES[1] 30-day maximum per Benefit Period	80%	60%
HOME HEALTH CARE SERVICES[1] 30 visit maximum per Benefit Period	80%	60%
HOSPICE SERVICES[1]	80%	60%
DENTAL SERVICES FOR ACCIDENTAL INJURY	80%	60%
DIABETES EQUIPMENT, SUPPLIES AND SELF-MANAGEMENT SERVICES	80%	60%
SERVICES RELATED TO CLINICAL TRIALS	80%	60%
DURABLE MEDICAL EQUIPMENT	80%	60%
PROSTHETIC APPLIANCES	80%	60%
ORTHOTIC DEVICES Maximum of 15 per Benefit Period	80%	60%
WIGS OR OTHER SCALP PROSTHESES Maximum of One per Benefit Period	80%	60%
ALL OTHER COVERED SERVICES	80%	60%

[1] *Subject to Preauthorization approval from the Plan. See the Contract for details regarding "Preauthorization" requirements.*

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BlueCross BlueShield of Oklahoma

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

Blue Preferred Gold PPO℠ 007
Blue Preferred PPO℠ Network
OUTLINE OF COVERAGE

READ YOUR POLICY CAREFULLY – This outline of coverage provides only a very brief description of the important features of your Contract. This is not the insurance Contract, and only the actual Contract provisions will control. The Contract itself sets forth in detail the rights and obligations of both you and Blue Cross and Blue Shield of Oklahoma. Changes in state or federal law or regulations or interpretations thereof may change the terms and conditions of coverage.

This coverage is designed to provide you with economic incentives for using participating health care providers.

It provides, to persons insured, coverage for Comprehensive Health Care Services incurred as a result of a covered accident or illness. Coverage is subject to any Copayment, Deductible and Coinsurance provisions, or other limitations and exclusions which may be set forth in the Contract.

Although you can go to any Provider of your choice, your Benefits under the Contract will be greater when you use the services of Network Providers.

The first premium must be paid with the application. Subsequent premiums are due by the premium due date specified in the member billing notice.

The Contract coverage will continue in force at your option. However, Blue Cross and Blue Shield of Oklahoma may non-renew or discontinue coverage for you and your Dependents for the following reasons:

- non-payment of premiums;
- fraud;
- termination of the particular type of coverage, or all coverage, in the individual market; or
- movement of you and/or your Dependents outside the Plan's service area.

This schedule shows the Deductibles, Copayments and/or Coinsurance amounts that apply to Covered Services described in the ***Comprehensive Health Care Services*** section of your Contract. Deductibles, Copayments, Coinsurance amounts and Out-of-Pocket Limits may be subject to change or increase as permitted by applicable law. **Please note that services must be Medically Necessary, as determined by the Plan, in order to be covered.**

COMPREHENSIVE HEALTH CARE SERVICES	
BENEFIT PERIOD/POLICY YEAR	Calendar Year
NETWORK PROVIDERS	To receive maximum Benefits under your Contract, you must receive services from Blue Preferred Providers in Oklahoma or BlueCard Providers outside the state of Oklahoma. Refer to www.bcbsok.com or call a Customer Service Representative at the number shown on your Identification Card to find a Network Provider near you.
OFFICE VISIT COPAYMENTS	The following Copayments will apply: • $30 for each visit to a Network Provider's office or Retail Health Clinic. • $30 for each visit to a Network Provider's office for Psychiatric Care Services. • $50 for each visit to a Network Specialist Physician's office. The Copayment applies to charges which are billed as part of the office visit, except for: • Preventive Care Services received from a Network Provider; • Annual mammography screening;

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COMPREHENSIVE HEALTH CARE SERVICES (CONTINUED)	
	• Covered childhood immunizations (for Subscribers under age 19); • Surgical services; • Physical Therapy, Occupational Therapy and Speech Therapy. **Copayments do not apply to services received from Out-of-Network Providers.**
DEDUCTIBLES	
Emergency Room Deductible	$400 for each visit to a Hospital emergency room. This Deductible is waived if you are admitted to the Hospital through the emergency room visit.
Outpatient Surgery Deductible	• $150 for each visit to a Network Outpatient facility for Surgery. This Deductible applies to surgical procedures received in a Hospital Outpatient department or Ambulatory Surgical Facility. • $250 for each visit to an Out-of-Network Outpatient facility for Surgery. This Deductible applies to surgical procedures received in an Out-of-Network Hospital Outpatient department or Ambulatory Surgical Facility.
Hospital Admission Deductible	• $200 for each admission to a Network Hospital. • $300 for each Out-of-Network Hospital Admission.
Benefit Period Deductible	• **Network Provider Services** –$1,000 per Benefit Period per Subscriber, or $3,000 for all covered family members combined. • **Out-of-Network Provider Services** –$2,000 per Benefit Period per Subscriber, or $6,000 for all covered family members combined. Deductible amounts for Network Provider Services and Out-of-Network Provider Services ***do not*** cross-apply. The Benefit Period Deductible is in addition to the Emergency Room Deductible, Outpatient Surgery Deductible and Hospital Admission Deductible described above. The Benefit Period Deductible applies to all Covered Services, except: • Network Physician services that are subject to the office visit Copayment. • Preventive Care Services received from a Network Provider. Preventive Care Services received from an Out-of-Network Provider are subject to Deductible, except for: – Annual routine gynecological/obstetrical examination and Pap smear; – Annual mammography screening; – Annual prostate cancer screening; – Covered childhood immunizations (for Subscribers under age 19); – Any other state or federally mandated Benefits which stipulate a Deductible may not be required.

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COMPREHENSIVE HEALTH CARE SERVICES (CONTINUED)	
OUT–OF–POCKET LIMIT	• Network Provider Services –$3,000 per Subscriber, or $9,000 for all covered family members combined. When this limit has been paid (including any Copayment and/or Deductible amounts) for Covered Services provided by Network Providers during a Benefit Period, the amount of Allowable Charges covered by the Plan for such Subscriber will increase to 100% during the remainder of the Benefit Period for Covered Services received from Network Providers. • Out-of-Network Provider Services –$6,000 per Subscriber, or $18,000 for all covered family members combined. When this limit has been paid (including any Deductible amounts) for Covered Services provided by Out-of-Network Providers during a Benefit Period, the amount of Allowable Charges covered by the Plan will increase to 100% during the remainder of the Benefit Period for Out-of-Network Provider services. Out-of-Pocket Limits for Network Provider Services and Out-of-Network Provider Services ***do not*** cross-apply. This Out-of- Pocket Limit does not include any of the following: • Services, supplies or charges limited or excluded by the Contract; • Expenses not covered because a Benefit maximum has been reached; • Any penalty incurred due to your failure to follow the Plan's requirements for Preauthorization, as set forth in the Contract.
BENEFIT PERCENTAGE AMOUNT	The following chart shows the percentage of Allowable Charges covered by the Contract through payments and/or contractual arrangements with Providers. These percentages apply only after your Deductibles and/or Copayment amounts have been satisfied. **NOTE: Any services classified as "Preventive Care Services" are paid at 100% of the Allowable Charge and are not subject to Copayments, Deductibles and/or Coinsurance, provided such services are received from Network Providers.**

COVERED SERVICES
(Subject to the *Comprehensive Health Care Services* section)

	BENEFIT PERCENTAGE OF ALLOWABLE CHARGES PAID BY THE PLAN	
	Network Provider Services	Out-of-Network Provider Services
PREVENTIVE CARE SERVICES		
Annual Mammography Screening	100%	100%
Covered Childhood Immunizations	100%	100%
All Other Covered Preventive Care Services	100%	70%
EMERGENCY CARE SERVICES	80%	80%
THE FOLLOWING BENEFIT PERCENTAGES APPLY TO SERVICES THAT ARE NOT CLASSIFIED AS PREVENTIVE CARE SERVICES OR EMERGENCY CARE SERVICES, AS DETERMINED BY THE PLAN		
HOSPITAL SERVICES[1]	80%	60%

[1] *Inpatient Hospital Services are subject to Preauthorization approval from the Plan. See the Contract for details regarding "Preauthorization" requirements.*

EXHIBIT 3
Page 3 of 12

COVERED SERVICES (Subject to the *Comprehensive Health Care Services* section)		
	BENEFIT PERCENTAGE OF ALLOWABLE CHARGES PAID BY THE PLAN	
	Network Provider Services	Out-of-Network Provider Services
SURGICAL/MEDICAL SERVICES		
Physician's Office Visit	100%[1]	70%
Retail Health Clinic Visit	100%[1]	70%
All Other Covered Surgical/Medical Services	80%	60%
OUTPATIENT DIAGNOSTIC SERVICES	80%	60%
OUTPATIENT THERAPY SERVICES Maximum of 25 Outpatient visits for Physical Therapy, Occupational Therapy and Speech Therapy (combined) per Benefit Period	80%	60%
MATERNITY SERVICES	80%	60%
MASTECTOMY AND RECONSTRUCTIVE SURGICAL SERVICES	80%	60%
HUMAN ORGAN, TISSUE AND BONE MARROW TRANSPLANT SERVICES[2]	80%	60%
AMBULATORY SURGICAL FACILITY SERVICES	80%	60%
SERVICES RELATED TO TREATMENT OF AUTISM AND AUTISM SPECTRUM DISORDERS Physical Therapy, Occupational Therapy and Speech Therapy limited to a combined maximum of 390 visits per Benefit Period for Subscribers under age six[3]	80%	60%
PSYCHIATRIC CARE SERVICES	80%	60%
AMBULANCE SERVICES	80%	80%
PRIVATE DUTY NURSING SERVICES[2] 85 visit maximum per Benefit Period	80%	60%
REHABILITATION CARE[2] 30-day maximum per Benefit Period	80%	60%
SKILLED NURSING FACILITY SERVICES[2] 30-day maximum per Benefit Period	80%	60%
HOME HEALTH CARE SERVICES[2] 30 visit maximum per Benefit Period	80%	60%
HOSPICE SERVICES[3]	80%	60%

[1] *Applicable only to Covered Services which are subject to the office visit Copayment. For services which are not subject to the office visit Copayment, this percentage amount is reduced to 80% of Allowable Charges after satisfaction of the Deductible.*

[2] *Subject to Preauthorization approval from the Plan. See the Contract for details regarding "Preauthorization" requirements.*

[3] *Refer to "Outpatient Therapy Services" for Physical Therapy, Occupational Therapy and Speech Therapy visits applicable to Subscribers age six and older.*

EXHIBIT 3
Page 4 of 12

COVERED SERVICES (Subject to the *Comprehensive Health Care Services* section)		
	BENEFIT PERCENTAGE OF ALLOWABLE CHARGES PAID BY THE PLAN	
	Network Provider Services	Out-of-Network Provider Services
DENTAL SERVICES FOR ACCIDENTAL INJURY	80%	60%
DIABETES EQUIPMENT, SUPPLIES AND SELF-MANAGEMENT SERVICES	80%	60%
SERVICES RELATED TO CLINICAL TRIALS	80%	60%
DURABLE MEDICAL EQUIPMENT	80%	60%
PROSTHETIC APPLIANCES	80%	60%
ORTHOTIC DEVICES Maximum of 15 per Benefit Period	80%	60%
WIGS OR OTHER SCALP PROSTHESES Maximum of One per Benefit Period	80%	60%
ALL OTHER COVERED SERVICES	80%	60%

EXCLUSIONS

What Is Not Covered

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

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

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EXCLUSIONS (CONTINUED)

- For cosmetic Surgery or complications resulting therefrom, including Surgery to improve or restore your appearance, unless:
  - needed to repair conditions resulting from an accidental injury; or
  - for the improvement of the physiological functioning of a malformed body member resulting from a congenital defect.

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

  Benefits are not provided for dental implants, grafting of alveolar ridges, or for any complications arising from such procedures.
- For or related to Inpatient treatment of any non-covered dental procedure, except that coverage shall be provided for Hospital Services, Ambulatory Surgical Facility Services, and anesthesia services associated with any Medically Necessary dental procedure when provided to a Subscriber who is:
  - severely disabled; or
  - eight years of age or under and who has a medical or emotional condition which requires hospitalization or general anesthesia for dental care; or
  - four years of age or under, who in the judgment of the practitioner treating the child, is not of sufficient emotional development to undergo a Medically Necessary dental procedure without the use of anesthesia.
- For eyeglasses, contact lenses or examinations for prescribing or fitting them, except for:
  - aphakic patients (including lenses required after cataract Surgery) and soft lenses or sclera shells to treat disease or injury;
  - vision examinations performed in connection with the diagnosis or treatment of disease or injury; or
  - services specified under "Preventive Care Services" or "Pediatric Vision Care Addendum".
- For eye Surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).
- For hearing aids, tinnitus maskers, or examinations for prescribing or fitting them, except as specified for Subscribers under age 18. 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".

EXHIBIT 3
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EXCLUSIONS (CONTINUED)

- For transsexual Surgery or any treatment leading to or in connection with transsexual Surgery.
- For diagnosis, treatment or medications for infertility and fertilization procedures. Examples include any form of: artificial insemination; ovulation induction procedures; in vitro fertilization; embryo transfer; or any other procedures, supplies or medications which in any way are intended to augment or enhance your reproductive ability.
- For treatment of sexual problems not caused by organic disease
- For treatment of obesity, including morbid obesity, regardless of the patient's history or diagnosis, including but not limited to the following: weight reduction or dietary control programs; surgical procedures; prescription or nonprescription drugs or medications such as vitamins (whether to be taken orally or by injection), minerals, appetite suppressants, or nutritional supplements; and any complications resulting from weight loss treatments or procedures.
- For smoking cessation programs, not including counseling as specified under "Preventive Care Services".
- For medication, drugs or hormones to stimulate growth.
- For or related to acupuncture, whether for medical or anesthesia purposes.
- For conditions related to hyperkinetic syndromes, learning disabilities, behavioral problems, mental retardation, or for Inpatient confinement for environmental change. This exclusion ***shall not*** apply to the following Medically Necessary services:
  - Services of a Physician or other Provider (except for neuropsychological testing) related to the diagnosis and treatment of attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD); or
  - Prescription Drug therapy for treatment of ADD/ADHD.
- For unspecified developmental disorders or autistic disease of childhood, except as specified in the ***Comprehensive Health Care Services*** section under "Services Related to Treatment of Autism and Autism Spectrum Disorders."
- For or related to applied behavior analysis.
- For family or marital counseling.
- For hippotherapy, equine assisted learning, or other therapeutic riding programs.
- For which the Provider of service customarily makes no direct charge to a Subscriber.
- For treatment of temporomandibular joint dysfunction, including but not limited to diagnostic procedures, splints, orthodontic/orthopedic appliances, restorations necessary to increase vertical dimension or to restore or maintain functional or centric occlusion, alteration of teeth or jaws, Physical Therapy, and medication and behavioral modification related to conditions of temporomandibular joint syndrome or any other conditions involving the jaw joint, adjacent muscles or nerves, regardless of cause or diagnosis.
- For or related to transplantation of donor organs, tissues or bone marrow, except as specified under "Human Organ, Tissue and Bone Marrow Transplant Services."
- For Physician standby services.
- For Continuous Passive Motion (CPM) devices used in treatment of the shoulder or other joints, except for up to 21 days postoperatively for the following surgical procedures: total knee arthroplasty, anterior cruciate ligament reconstruction, or open reduction and internal fixation of tibial plateau for distal femur fractures involving the knee joint.
- For ductal lavage of the mammary ducts.
- For extracorporeal shock wave treatment, also known as orthotripsy, using either a high-or low-dose protocol, for treatment of plantar fasciitis and all other musculoskeletal conditions.
- For orthoptic training.
- For thermal capsulorrhaphy as a treatment of joint instability, including but not limited to instability of shoulders, knees and elbows.
- For elective abortion, unless the life or health of the mother is endangered.
- For transcutaneous electrical nerve stimulator (TENS).
- For Inpatient drug and alcohol treatment that is not rendered in a Hospital, Psychiatric Hospital, Residential Treatment Center or other Plan-approved Provider.
- For massage therapy, including but not limited to effleurage, petrissage and/or tapotement.
- Which are not specifically named as Covered Services subject to any other specific Exclusions and limitations in the Contract.

We may, without waiving these Exclusions, elect to provide Benefits for care and services while awaiting the decision of whether or not the care and services fall within the Exclusions listed above. If it is later determined that the care and services are excluded from your coverage, we will be entitled to recover the amount we have allowed for Benefits under the Contract. You must provide to us all documents needed to enforce our rights under this provision.

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OUTPATIENT PRESCRIPTION DRUGS		
BENEFIT PERIOD/POLICY YEAR	Calendar Year	
DEDUCTIBLE	None. Your Benefits for Outpatient Prescription Drugs and related services are *not* subject to the Benefit Period Deductible set forth in the ***Schedule of Benefits for Comprehensive Health Care Services***.	
OUT-OF-POCKET LIMIT	Your Benefits for Outpatient Prescription Drugs and related services are subject to the Out-of-Pocket Limit set forth in the ***Schedule of Benefits for Comprehensive Health Care Services.***	
COPAYMENT/COINSURANCE	The Copayment/Coinsurance amount applicable to each Prescription Order is set forth below. **In addition to your Copayment and/or Coinsurance amounts, when your Prescription Order is filled at an Out-of-Network Pharmacy you will be responsible for the cost difference, if any, between the Pharmacy's billed charges and the Allowable Charge determined by the Plan.**	
	Copayment/Coinsurance Amounts per Prescription Order For Which You Are Responsible	
Retail Pharmacy Program (30-Day Supply)	**Participating Retail Pharmacy**	**Out-of-Network Retail Pharmacy**[1]
Preferred Generic Drugs	No Copayment	50% of Allowable Charges
Non-Preferred Generic Drugs	$10 Copayment	$10 Copayment plus 50% of Allowable Charges
Preferred Brand Drugs	$50 Copayment	$50 Copayment plus 50% of Allowable Charges
Non-Preferred Brand Drugs	$100 Copayment	$100 Copayment plus 50% of Allowable Charges

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

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OUTPATIENT PRESCRIPTION DRUGS (CONTINUED)			
	Copayment/Coinsurance Amounts per Prescription Order For Which You Are Responsible		
Extended Retail Prescription Drug Supply Program (90-Day Supply)	**Quantity Dispensed**	**Participating Extended Supply Retail Pharmacy**	**Any Pharmacy other than the Participating Extended Supply Retail Pharmacy**
Preferred Generic Drugs	1 to 90 days	No Copayment	Not Covered
Non-Preferred Generic Drugs	1 to 30 days	$10 Copayment	Not Covered
	31 to 60 days	$20 Copayment	
	61 to 90 days	$30 Copayment	
Preferred Brand Drugs	1 to 30 days	$50 Copayment	Not Covered
	31 to 60 days	$100 Copayment	
	61 to 90 days	$150 Copayment	
Non-Preferred Brand Drugs	1 to 30 days	$100 Copayment	Not Covered
	31 to 60 days	$200 Copayment	
	61 to 90 days	$300 Copayment	

	Copayment/Coinsurance Amounts per Prescription Order For Which You Are Responsible	
Mail-Order Pharmacy Program (90-Day Supply)	**Participating Mail-Order Pharmacy**	**Any Pharmacy other than the Participating Mail-Order Pharmacy**
Preferred Generic Drugs	No Copayment	Not Covered
Non-Preferred Generic Drugs	$20 Copayment	
Preferred Brand Drugs	$100 Copayment	
Non-Preferred Brand Drugs	$200 Copayment	
	Copayment/Coinsurance Amounts per Prescription Order For Which You Are Responsible	
	Specialty Network Pharmacy	**Any Pharmacy other than a Specialty Network Pharmacy[1]**
Specialty Pharmacy Program (30-Day Supply)	$150 Copayment	$150 Copayment plus 50% of Allowable Charges

Brand Name Drug Selection

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

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

EXHIBIT 3
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EXCLUSIONS

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

- Drugs which by law do not require a Prescription Order from an authorized Provider (except insulin, insulin analogs, insulin pens, and prescriptive and nonprescriptive oral agents for controlling blood sugar level); and drugs, insulin or covered devices for which no valid Prescription Order is obtained.
- Over-the-counter drugs and medications, except those prescribed by a Physician or other Provider as part of the "Preventive Care Services" as defined in the Contract.
- Devices or Durable Medical Equipment of any type (even though such devices may require a Prescription Order), such as, but not limited to, therapeutic devices, artificial appliances, or similar devices (**except** disposable hypodermic needles and syringes for self-administered injections.)
- Administration or injection of any drugs (except for vaccines administered by a Participating Pharmacy).
- Vitamins (**except** those vitamins which by law require a Prescription Order and for which there is **no** non-prescription alternative).
- Drugs dispensed in a Physician's office or during confinement while a patient in a Hospital, or other acute care institution or facility, including take-home drugs; and drugs dispensed by a nursing home or custodial or chronic care institution or facility.
- Covered Drugs, devices, or other Pharmacy services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States (including but not limited to, any services or supplies for which benefits are payable under Part A and Part B of Title XVIII of the Social Security Act (Medicare), or the laws, regulations or established procedures of any county or municipality, except any program which is a state plan for medical assistance (Medicaid), or any Prescription Drug which may be properly obtained without charge under local, state, or federal programs, unless such exclusion is expressly prohibited by law; provided, however, that this exclusion shall not be applicable to any coverage held by the Member for prescription drug expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.
- Any services provided or items furnished for which the Pharmacy normally does not charge.
- Covered Drugs for which the Pharmacy's usual and customary charge to the general public is less than or equal to the Copayment or Coinsurance amount provided under the Contract.
- Infertility and fertility medications.
- Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.
- Drugs required by law to be labeled: "Caution – Limited by Federal Law to Investigational Use", or Experimental drugs, even though a claim is made for the drugs.
- Covered Drugs dispensed in quantities in excess of the amounts stipulated in the ***Outpatient Prescription Drugs and Related Services*** section; or refills of any prescriptions in excess of the number of refills specified by the Physician or by law; or any drugs or medicines dispensed more than one year following the Prescription Order date.
- Drugs which are not approved by the U.S. Food and Drug Administration (FDA) for a particular use or purpose or when used for a purpose other than the purpose for which the FDA approval is given, except as required by law or regulation. This exclusion is not applicable to the coverage of the off-label use of Prescription Drugs for the treatment of cancer or the study of oncology in accordance with Oklahoma law.
- Fluids, solutions, nutrients, medications (including all additives and Chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous, intramuscular (in the muscle), intrathecal (in the spine), or intraarticular (in the joint) injection in the home setting, except as specifically provided in the Contract. NOTE: This exception does not apply to dietary formula necessary for the treatment of phenylketonuria (PKU) or other heritable diseases.
- Drugs prescribed and dispensed for the treatment of obesity or for use in any program of weight reduction, weight loss, or dietary control.
- Drugs the use or intended use of which would be illegal, unethical, imprudent, abusive, not Medically Necessary, or otherwise improper.
- Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the Identification Card.
- Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury, or bodily malfunction which is not covered under the Contract, or for which Benefits have been exhausted.
- Rogaine, Minoxidil or any other drugs, medications, solutions or preparations used or intended for use in the treatment of hair loss, hair thinning or any related condition, whether to facilitate or promote hair growth, to replace lost hair, or otherwise.
- Cosmetic drugs used primarily to enhance appearance, including, but not limited to, correction of skin wrinkles and skin aging.

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EXCLUSIONS (CONTINUED)

- Prescription Orders for which there is an over-the-counter product available with the same active ingredient(s), in the same strength, unless otherwise determined by the Plan.
- Athletic performance enhancement drugs.
- Drugs to treat sexual dysfunction or erectile dysfunction, including, but not limited to, sildenafil citrate (Viagra), phentolamine (Regitine), alprostadil (Prostin, Edex, Caverject), and apomorphine.
- Compounded medications. For purposes of this exclusion, "compounded medications" are substances made by mixing, reconstituting or other such acts, not in accordance with directions contained in Food and Drug Administration (FDA) approved labeling provided by the product's manufacturer and other FDA-approved manufacturer directions consistent with that labeling.
- Replacement of drugs or other items that have been lost, stolen, destroyed, or misplaced
- Shipping, handling, or delivery charges.
- Prescription Drugs required for international travel or work.
- Certain drug classes where there are over-the counter alternatives available.
- Drugs which are repackaged by a company other than the original manufacturer.

Brand Name Drug Exclusion

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

PEDIATRIC VISION CARE BENEFITS

Vision Care Services	In-Network Subscriber Cost or Discount (When a fixed-dollar Copayment is due from the Subscriber, the remainder is payable by the Plan up to the Allowable Charge[1])	Out-of-Network Allowance (Maximum amount payable by Plan, not to exceed the retail cost[2])
Exam (with dilation as necessary):	No Copayment	Up to $30
Frames:		
"Collection" Frames	No Copayment	Up to $30
Frequency: Examination, Frames, Lenses, or Contact Lenses	Once every Calendar Year	
Standard Plastic, Glass, or Poly Spectacle Lenses:		
Single Vision	No Copayment	Up to $25
Lined Bifocal	No Copayment	Up to $35
Lined Trifocal	No Copayment	Up to $45
Lenticular	No Copayment	Up to $45
Lens Options (add to lens prices above):		
Ultraviolet Protective Coating	No Copayment	Not covered
Polycarbonate Lenses	No Copayment	
Blended Segment Lenses	$20 Copayment	
Intermediate vision Lenses	$30 Copayment	
Standard Progressives	No Copayment	
Premium Progressive (Varilux®, etc.)	$90 Copayment	
Photochromic Glass Lenses	$20 Copayment	
Plastic Photosensitive Lenses (Transitions®)	No Copayment	
Polarized Lenses	$75 Copayment	
Standard Anti-Reflective (AR) Coating	$35 Copayment	
Premium AR Coating	$48 Copayment	
Ultra AR Coating	$60 Copayment	
High Index Lenses	$55 Copayment	

[1] *The "Allowable Charge" is the rate negotiated with Network Providers for a particular Covered Service.*
[2] *The Plan pays the lesser of the maximum allowance noted or the retail cost. Retail prices vary by location.*

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PEDIATRIC VISION CARE BENEFITS (CONTINUED)		
Progressive Lens Options – Subscribers may receive a discount on additional progressive lens options: Select Progressive Lenses Ultra Progressive Lenses	 $70 Copayment $195 Copayment	Not covered
For additional options and added features refer to your Contract.		

EXCLUSIONS

In addition to the ***Exclusions*** listed in your Contract, 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 your failure to comply with professionally prescribed treatment;
- telephone consultations;
- any services that are strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
- services or materials provided as a result of intentionally self-inflicted injury or illness;
- services or materials provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
- office infection control charges;
- charges for copies of your records, charts, or any costs associated with forwarding/mailing copies of your records or charts;
- state or territorial taxes on vision services performed;
- medical treatment of eye disease or injury;
- visual therapy;
- special lens designs or coatings other than those described in your Contract;
- replacement of lost/stolen eyewear;
- non-prescription (Plano) lenses;
- two pairs of eyeglasses in lieu of bifocals;
- services not performed by licensed personnel;
- prosthetic devices and services;
- insurance of contact lenses;
- professional services you receive from immediate relatives or household members, such as a spouse, parent, child, brother or sister, by blood, marriage or adoption;
- services covered under your ***Comprehensive Health Care Services.***

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BlueCross BlueShield of Oklahoma
PO. Box 3283
Tulsa, Oklahoma 74102-3283

THIS IS A DUPLICATE.
Explanation of Benefits (EOB). **This is not a bill.**
BLUE CROSS/BLUE SHIELD
05-29-14

CHRISTINA R TERRY
321 S ROBINSON
MANGUM OK 73554-4611

Customer Service: 1-866-520-2507

Blue goes Green. EOB statements for members owing providers zero dollar amounts are only available through customer service or Blue Access for Members at www.bcbsok.com. Some exclusions apply.

Claim Information

Member Name:	CHRISTINA R TERRY
Group No.:	**OG2009**
Identification No.:	**YUI927705055**
Claim No.:	403650G41710X
Patient Name:	[redacted]

SUMMARY

Total Billed:	**$49999.00**
Total Benefits Approved:	**$0.00**
Amount You May Owe Provider:	**$0.00**

SERVICE INFORMATION

	Service Date	Amount Billed	Not Covered	Covered
ROCKY MOUNTAIN HOLDINGS LLC				
Air Ambulance	01-14-14	25221.62	25221.62 (1)	0.00
Air Ambulance	01-14-14	24777.38	24777.38 (1)	0.00
Totals		$49999.00	$49999.00	$0.00

COVERAGE INFORMATION

Totals	$49999.00	$49999.00	$0.00
Total Benefits Approved			$0.00
Amount You May Owe Provider			$0.00

Information About Amounts Not Covered

(1) Your claim has been denied. We have requested additional information from your provider which is required in order to process this claim. Your claim will be processed when this additional information is received. No payment can be made at this time.

Health Care Fraud Notice **Fraud Hotline at 1-800-543-0867**
Health care fraud affects us all and causes an increase in health care costs. If you suspect any person or company of defrauding or attempting to defraud Blue Cross and Blue Shield of Oklahoma, please call us. All calls are confidential and you may report your suspicions anonymously via our toll free hotline. For more information about health care fraud, please go to www.bcbsok.com/sid.

Information About Appeals

Please refer to your Certificate of Benefits booklet for further explanation of the terms, conditions, limitations and exclusions

(turn over)

44,638 OK2573

EXHIBIT 4
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Information About Appeals

applicable to your benefits.

You have the right to appeal this decision within 180 days. For a full description of the Appeal Process, please refer to your Certificate of Benefits booklet. If you wish to appeal, please send your written request to:

Attention: Customer Service Appeal Coordinator
Blue Cross and Blue Shield of Oklahoma
P. O. Box 3283
Tulsa, OK 74102-3283

The written request should include the name of the Subscriber, the Subscriber identification number, the nature of the complaint, the facts upon which the complaint is based, and the resolution you are seeking. Necessary facts are: dates and places of services, names of Providers of services, place of hospitalization and types of services or procedures received (if applicable). You and/or your Provider should include any documentation, including medical records, that you want to become a part of the review file. The Plan may request further information if necessary.

If your benefit determination involved a rule or guideline or a medical necessity or experimental/investigational treatment decision, you may receive upon request, free of charge, a copy of the rule or guideline or an explanation of the decision.

If your benefit plan is governed by ERISA, you may have the right to take legal actions under Sec. 502 (a) of ERISA if the benefit decision is upheld on appeal.

NOTICE OF APPEAL RIGHTS
(Retain for your records)

This document applies to your BlueCross and BlueShield of Oklahoma (BCBSOK) policy. Any conflicts between the statements below and rights stated elsewhere in this notice (or in your policy or Benefit Plan), will be resolved so that those rights that are more beneficial to you will apply, unless the law requires otherwise.
If we have denied your claim for benefits, in whole or in part, for a requested treatment or service, rescinded your coverage, or denied or limited your eligibility (if applicable), then this document serves as part of your notice of an adverse determination.
Contact us at the number on the back of your ID card if you need assistance understanding this notice or your adverse determination, the reason for the denial, why the health care service or treatment was not fully covered, or why a request for coverage of a service was denied.

Your Internal Appeal Rights

What if I don't agree with this decision? You have a right to appeal an adverse determination. However, you only have 180 days from the date you receive the notice of adverse determination to file an internal appeal. We will provide a full and fair review of your claim by individuals associated with us, but who were not involved in making the initial denial of your claim. If your claim was denied due to missing or incomplete information, you or your health care provider may submit the claim to us with the necessary information to complete the claim without exhausting your internal appeal rights.
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Blue Cross and Blue Shield of Oklahoma
P.O. Box 3122
Naperville, IL 60566-9744
Fax: (888)235-2936

What about eligibility-related denials and rescissions? Please refer to your benefit booklet for additional specifics. You may also contact us at:

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BlueCross BlueShield of Oklahoma
PO. Box 3283
Tulsa, Oklahoma 74102-3283

NOTICE OF APPEAL RIGHTS
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Blue Cross and Blue Shield of Oklahoma
P.O. Box 3122
Naperville, Illinois 60566-9744
Phone: (866)520-2507
Fax: (888)235-2936

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Can I provide additional information about my claim? Yes, you will be informed about how to supply additional information once you initiate your appeal. You may also have the option of presenting evidence and testimony. In addition, we may provide you with any new or additional evidence, rationale, documents, or information used or relied upon in your adverse determination so you have a reasonable opportunity to respond before a final decision is made.

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Oklahoma Department of Insurance
Five Corporate Plaza
3625 NW 56th Street,
Oklahoma City, Oklahoma 73112-4511
Telephone: (800)522-0071 or (405)521-2828

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Other Resources to Help You

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44,640 OK2573

EXHIBIT 4
Page 3 of 4

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44,641 OK2573

EXHIBIT 4
Page 4 of 4

BlueCross BlueShield
of Oklahoma
PO. Box 3283
Tulsa, Oklahoma 74102-3283

THIS IS A DUPLICATE.
Explanation of Benefits (EOB). **This is not a bill.**
BLUE CROSS/BLUE SHIELD
09-04-14

CHRISTINA R TERRY
321 S ROBINSON AVE
MANGUM OK 73554-4611

Customer Service: 1-866-520-2507

Blue goes Green. EOB statements for members owing providers zero dollar amounts are only available through customer service or Blue Access for Members at www.bcbsok.com. Some exclusions apply.

Claim Information

Member Name:	CHRISTINA R TERRY
Group No.:	**OG2009**
Identification No.:	**YUI927705055**
Claim No.:	403650G41710X
Patient Name:	[redacted]

SUMMARY

Total Billed:	**$49999.00**
Total Benefits Approved:	**$2909.92**
Amount You May Owe Provider:	**$47089.08**

We have reviewed the claim which was previously processed for this patient. The following shows how this claim was adjusted.

SERVICE INFORMATION

	Service Date	Amount Billed	Not Covered	Covered
ROCKY MOUNTAIN HOLDINGS LLC				
Air Ambulance	01-14-14	25221.62	20405.41 (1)	4816.21
Air Ambulance	01-14-14	24777.38	24743.73 (1)	33.65
Totals		$49999.00	$45149.14	$4849.86

COVERAGE INFORMATION

Totals	$49999.00	$45149.14	$4849.86
Total Benefits Approved			$2909.92
Amount You May Owe Provider			$47089.08

Payment of $2,909.92 was made to CHRISTINA R TERRY on 09-04-14 check number 24759444.

Information About Amounts Not Covered

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Health Care Fraud Notice **Fraud Hotline at 1-800-543-0867**

Health care fraud affects us all and causes an increase in health care costs. If you suspect any person or company of defrauding or attempting to defraud Blue Cross and Blue Shield of Oklahoma, please call us. All calls are confidential and you may report your suspicions anonymously via our toll free hotline. For more information about health care fraud, please go to www.bcbsok.com/sid.

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36,900 OK2572

EXHIBIT 5
Page 1 of 4

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36,902 OK2572

EXHIBIT 5
Page 3 of 4

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36,903 OK2572

EXHIBIT 5
Page 4 of 4

BlueCross BlueShield of Oklahoma
PO. Box 3283
Tulsa, Oklahoma 74102-3283

THIS IS A DUPLICATE.
Explanation of Benefits (EOB). **This is not a bill.**
BLUE CROSS/BLUE SHIELD
10-07-14

CHRISTINA R TERRY
321 S ROBINSON AVE
MANGUM OK 73554-4611

Customer Service: 1-866-520-2507

Blue goes Green. EOB statements for members owing providers zero dollar amounts are only available through customer service or Blue Access for Members at www.bcbsok.com. Some exclusions apply.

Claim Information

Member Name:	CHRISTINA R TERRY
Group No.:	**OG2009**
Identification No.:	**YUI927705055**
Claim No.:	40365064171QX
Patient Name:	[redacted]

SUMMARY

Total Billed:	**$49999.00**
Total Benefits Approved:	**$4849.86**
Amount You May Owe Provider:	**$45149.14**

We have reviewed the claim which was previously processed for this patient. The following shows how this claim was adjusted.

SERVICE INFORMATION

	Service Date	Amount Billed	Not Covered	Covered
ROCKY MOUNTAIN HOLDINGS LLC				
Air Ambulance	01-14-14	25221.62	20405.41 (1)	4816.21
Air Ambulance	01-14-14	24777.38	24743.73 (1)	33.65
Totals		**$49999.00**	**$45149.14**	**$4849.86**

COVERAGE INFORMATION

Totals	**$49999.00**	**$45149.14**	**$4849.86**
Total Benefits Approved			**$4849.86**
	Prior Payment	(Minus)	-2909.92
	Additional Payment		1939.94
Amount You May Owe Provider			**$45149.14**

Payment of $1,939.94 was made to CHRISTINA R TERRY on 10-07-14 check number 24800943.

SUMMARY

Total Billed:	**$155.00**
Total Benefits Approved:	**$102.39**
Amount You May Owe Provider:	**$0.00**

Claim No.: 4279500223P0X
Patient Name: GRASON R TERRY

SERVICE INFORMATION

	Service Date	Amount Billed	Not Covered	Covered
PAUL FIRTH MD PC				
Routine Baby Care	10-01-14	155.00	52.61 (2)	102.39
Totals:		**$155.00**	**$52.61**	**$102.39**

COVERAGE INFORMATION

Totals	**$155.00**	**$52.61**	**$102.39**
Total Benefits Approved			**$102.39**
Amount You May Owe Provider			**$0.00**

Total covered benefits approved for this claim $102.39 to PAUL FIRTH III MD PC on 10-07-14

Information About Amounts Not Covered

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39,635 OK2572

EXHIBIT 6
Page 2 of 4

BlueCross BlueShield of Oklahoma
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39,636 OK2572

EXHIBIT 6
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For questions about your rights, this notice, or for assistance, you can contact the Oklahoma consumer assistance program of the Oklahoma Department of Insurance. To receive assistance, please refer to the contact information for the Department listed above or this website: www.ok.gov/oid/Consumers.

You may be eligible to receive your adverse determination and this notice in a language listed below. In addition, you may call us to receive assistance in these languages.

SPANISH (Español): Para asistencia en Español, por favor llame al numero ubicado en la parte posterior de su tarjeta de identificación.

TAGALOG (Tagalog): Upang humingi ng tulong sa Tagalog, paki tawagan ang numero na nakasulat sa inyong kard.

CHINESE (中文): 如果需要中文幫助，請撥打您卡上的電話號碼。

NAVAJO (Dine): Dinék'ehjí áka'a'doowoo ł biniiyé, t'áá shǫǫdi kojį' hodíílnih béésh bee hane'í bi numbo bee néé ho'dólzinígíí biniiyé nanitinígíí bine'dęę' bikáá'

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CM - 2029178400

OG 2 0 0 9 9 2 7 7 0 5 0 5 5

Blue Cross Blue Shield of Oklahoma
PO Box 3239
Naperville, IL 60566-7239

December 30, 2017

CHRISTINA TERRY
321 S ROBINSON
MANGUM OK 73554

Group Number: OG2009
Identification Number: 927705055
Patient Name: [redacted]
Claim Number: 0201403650G41710X 02
Patient Number: 146343
Service Date: January 14, 2014
Regarding: Copy of Appeal Request

Dear Member:

IMPORTANT UPDATES ENCLOSED

We have been asked to reconsider Grason's claim for services that Rocky Mountain Holdings Llc provided on the above service date(s).

Please be aware that we thoroughly reviewed your claim(s), but must maintain our benefit determination. Based on the information available to us, including the information you provided, we have determined that we processed the claim correctly. Therefore, no further reimbursement can be paid.

Reason for denial: We have reviewed this claim and determined that the Allowed Amount was determined correctly.

This is pertaining to your request for copy of appeal denial letter, please contact the department of insurance to get copies of final determination of documents.

For around-the-clock access to the latest information to help you better manage your health care decisions, log in to Blue Access® for Members at the Web site listed below.

Not yet a registered user? Blue Access for Members provides secure, immediate access to check the status of a claim, locate a network health care provider, view Explanation of Benefits statements, read about important wellness topics each month, and use a variety of online decision support tools.

We appreciate the opportunity to assist you in this matter.

Sincerely,

Customer Advocate - U334912
Blue Cross and Blue Shield
Retail Service Center

EXHIBIT 7
Page 1 of 1

BlueCross BlueShield of Oklahoma

April 04, 2018

Christina Terry
321 S. Robinson
Mangum OK 73554

Subscriber: Christina Terry
Group/Sub. No.: OG2009/000927705055
Claim No.: 403650G41710X 02
Appeal ID No.: 529889057
Appeal Type: Member's Authorized Representative

Phone: (866)520-2507
Fax: (918)551-2011
Email: SDOAppeals@bcbsil.com

Subject: Here are your copies

Dear Christina Terry:

Enclosed are the copies of your appeal documents you requested. Also included are the benefit term(s) or rule(s) we used for our review. Please see the copy of our decision letter to learn more about other appeal rights you may have.

If you have questions, please contact Customer Service at the number above.

Sincerely,

Marlynn G.

MARLYNN G.
Appeals Specialist 1
Appeals Department

Attachment:
MAP
OID 48469
BB_Terry
SOB_Terry
Outline_Terry
OID 48469_Terry_final letter

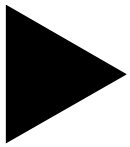
EXHIBIT 8

Air ambulance lawsuit could become class action

POSTED 6:00 PM, JULY 13, 2016, BY SARAH STEWART, *UPDATED AT 02:15PM, JULY 14, 2016*

This is an archived article and the information in the article may be outdated. Please look at the time stamp on the story to see when it was last updated.

Air Ambulance lawsuit



Former OSU basketball coach, Tommy Wade, was on his usual run April 7, 2015 when something went terribly wrong.

“I had a heart attack,” said Wade. “Collapsed right in front of the OSU police department.”

Wade had to be airlifted from Stillwater Medical Center to the Heart Hospital in Oklahoma City.

He says the bill for that ride shocked him.

“$38,000 for a 20 minute air flight from Stillwater to Oklahoma City?” said Wade.

EXHIBIT 9

And Wade had insurance, good insurance, that had already paid the air ambulance company what they felt was sufficient.

The company was coming after Wade for the balance.

“I told them I can’t pay the bill. I can’t afford it,” said Wade.

Attorneys Noble McIntyre and Ed White are representing more than a dozen clients with similar stories and they’ve now asked the judge to certify the lawsuit as class action.

They say in many instances, these companies will claim to be out of network, leaving a heavy burden on the patient.

“You’re price gouging innocent people who have already been victimized,” said McIntyre.

The lawsuit names four defendants – Air Evac EMS, Inc., Air Methods Corporation, Rocky Mountain Holdings, LLC and Eaglemed LLC.

They’re asking the court to refund money to those who have already been charged and to come up with fair billing practices so this doesn’t happen again.

“They’re making profit margins of in excess of 750%. These are huge profit margins they’re trying to get from the average public,” said White.

Wade says the company, Rocky Mountain Holdings, LLC, hounded him for months, trying to get him to pay the bill.

“They were relentless. They were you know they didn’t really let up until I got legal assistance,” said Wade.

He hopes this lawsuit can prevent this from happening to anyone else.

“I wouldn’t want anybody to have to go through that,” said Wade.

We received this statement from EagleMed.

“We are still looking into the allegations and prefer not to discuss ongoing litigation, especially when all we have is the initially filed Petition. EagleMed has been, and currently is, in network with Blue Cross Blue Shield of Oklahoma – the largest insurer in the State. At this point, we don’t know why we were sued if our patient had BCBS insurance. We would expect the BCBS agreement to deal with this situation. The only other EagleMed patient was said to have United Health Care insurance, which covered about half of the cost. If our patients need financial assistance with our invoices, we work with them – and we ask them to work with us when their insurance company underpays for services. We still would like to take our patient out of the middle and see if United Health Care will pay usual and customary rates.”

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And we received this statement from Air Evac Lifeteam.

'Air Evac Lifeteam is still looking into the allegations and prefer not to discuss ongoing litigation, especially when all we have is the initially filed Petition. At this point, we don't know why we were sued. Based on the Petition, the only claim against Air Evac is for transporting a patient who was injured in an on-the-job incident. We would expect an on-the-job injury to be covered by workers' compensation with no patient financial responsibility. In addition, Air Evac has been, and currently is, in network with Blue Cross Blue Shield of Oklahoma – the largest insurer in the state. Caring for our patients doesn't stop when we get them to the hospital. If our patients need financial assistance with our invoices, we work with them - and we ask them to work with us when their insurance company underpays for services.'

EXHIBIT 9

EDITORIAL

http //www stltoday com/opinion/editorial/editorial health insurance company makes big profits by playing hardball/article 265b6c91 75f7 5dbb a8d2 6038e2cfffea html

Editorial: Health insurance company makes big profits by playing hardball

By the Editorial Board Mar 15, 2018

The Anthem corporate headquarters in Indianapolis

In the past year, the health insurance company Anthem Blue Cross Blue Shield drew attention for stiffing patients in Missouri and other states for seeking emergency care that Anthem later decided wasn't an emergency. It also drew

EXHIBIT 10

attention for dropping out of the Affordable Care Act insurance marketplace in many places (including most of the St. Louis area) because it wasn't making enough money.

On Sunday, we learned that Anthem refused to cover the full $32,000 bill for a South County boy airlifted to a St. Louis hospital because the helicopter ambulance was "out of network."

Meanwhile, Anthem reported in late January that its fourth-quarter profits for 2017 had increased by 234 percent to $1.2 billion over the fourth quarter of 2016. Part of that was $1.1 billion in savings from the federal tax reform bill. Anthem paid an effective tax rate of 3.1 percent in 2017.

America's second-largest health insurer, with 39 million members, Anthem is making a lot of money and skating on a fair share of taxes. Premiums are higher and benefits are harder to get. Private profits shouldn't be the central concern of the U.S. health care system.

Missouri, Kentucky and Georgia were the first three states where Anthem rolled out more stringent emergency room policies. The idea was to hold down costs by making patients think twice about whether their emergency was really an emergency.

Granted, emergency services are sometimes overused, particularly by uninsured patients who use ERs as doctor's offices. And hospital charges can be outrageous. But the kind of self-diagnosis now required by Anthem has an obvious problem: If people knew they only had indigestion and not a heart attack, they'd stay home and eat Tums.

Critics, including ER physicians, the Missouri Hospital Association and Sen. Claire McCaskill, D-Mo., say Anthem's reliance on discharge codes — a doctor's shorthand summaries once a diagnosis has been made — is a poor measurement.

Anthem amended its policy to say it would always pay under certain conditions — but some Missouri lawmakers say that's not good enough. House Bill 2225 and Senate Bill 928 say an emergency room physician should determine what's an emergency and what's not.

The lawmakers might want to amend their bills so that families like Ben Millheim's don't get surprised at $32,000 charges for a helicopter evacuation. The Post-Dispatch's Samantha Liss reported Sunday that Ben, who is now 8, suffered a fractured skull on a camping trip in 2016 and was airlifted 83 miles to a St. Louis hospital. Anthem and the helicopter company had never decided on what was an appropriate charge so the Millheim family was stuck with the difference.

Such flights are scary enough, and rare enough, that they should be covered in their entirety if a physician advises it. It's obvious that Anthem can afford it.

Health Insurance Basics

Health insurance is an important coverage that helps protect you and your family from the devastating financial effects of unexpected health problems or catastrophic illness and as of January 1, 2014, most Americans are now required by Federal Law to have health insurance or pay a penalty.

The Oklahoma Insurance Department encourages you to work with the insurance professionals in your community to help you determine the appropriate policy for your family or business needs. These insurance professionals can be found on our website under:

Look Up Licensee by Name or Business

2017 CMS Certified Oklahoma Agents Listing

Federal Health Care Reform Resources

Click the image above to find out which private insurance plans, public programs and community services are available to you.

You may receive health coverage through an individual insurance policy, through a policy issued to you as a member of an association group, through an employer sponsored health plan or through a government plan (Medicare, SoonerCare (Medicaid), VA, etc.). If your employer sponsored health plan is "self insured" it is not subject to regulation by the Oklahoma Insurance Department but regulated by the Department of Labor. Additional information regarding employer sponsored plans is available below. The three main types of health insurance are:

- Policies that offer traditional health insurance;
- Policies that provide managed care services; and
- Policies that provide limited benefits.

Traditional Health Insurance

With the passage for the Affordable Care Act or Healthcare Reform in 2010, most traditional health insurance plans, often called "fee-for-service," are most l kely now to be found in "Grandfathered Plans", non-compliant ACA plans or commonly known as "Grandmother Plans" or Medicare Supplement Plans. If your plan is a true "free for service":

- You can use any doctor or hospital.
- You send your medical bills to the insurance company (the provider may do this for you but is not required).
- You will likely have to pay a deductible to your provider before the policy begins to pay and co-payments to your provider each time you visit your provider or doctor's office.
- If the policy pays less than the full bill, you most likely will be responsible for paying the balance.

ACA compliant group health and individual policies fall under the category of comprehensive medical policies. These ACA compliant policies are expensive because they are required by Federal law to provide more benefits than many older or pre-ACA policies. An ACA compliant policy pays a percentage of covered expenses (for example, 60%, 70%, 80% or 90%), after you pay the applicable plan deduct ble and copays. The remaining expense (for example,10%, 20%, 30% or 40%) is coinsurance and is paid by you. Maximum out-of-pocket limits restrict the amount of coinsurance you pay. After the covered person or family reaches their maximum out-of-pocket limit, your plan will pay 100% for that person or family for the rest of that year. Pay particular attention to the plan's maximum out of pocket limit before you buy a plan particularly if you are not eligible for cost sharing reductions on the federal exchange.

Policies that provide Managed Care Services

ACA compliant policies will often be tied to a provider care network. This affects your choice of doctors and hospitals because not all providers are part of the network. In return for this limited choice, you usually pay less for medical care (i.e., doctor visits, prescriptions, surgery and other covered benefits) than you would with traditional "fee-for-service" health insurance. The managed care network controls health care services in these narrower network options Be sure to review all providers available to you under each type of Managed Care Service network you choose.

If your health care provider is out-of-network, you are respons ble for the difference between the allowed amount and the provider's charge and those amounts will not be applied toward your out-of-pocket limits. It is imperative that you contact your insurer should you have any question regarding a health provider being an in-network or out-of-network provider. Out- of- network providers can be far more costly as they are not subject to your insurer's provider contract/s or discounted fee for services, however ACA compliant polices must cover emergency services received by an out-of-network provider as if they were in-network.

The types of Managed Care Networks are:

- **Preferred Provider Organizations (PPOs)** - PPOs offer a provider network to meet the health care needs of an insurance carrier's insureds. The insurer contracts with a group of health care providers, or with a PPO network, to control the cost of providing benefits to their insureds. These providers charge lower-than-usual fees because they require prompt payment and serve a greater number of patients. Insured's usually choose who will provide their health care, but pay less in coinsurance with a preferred provider than with a non-preferred provider.
- **Health Maintenance Organization (HMO)** - HMO members pay a monthly fixed dollar amount (similar to an insurance premium), which gives them access to a wide range of health care services. In many cases, members also pay a predetermined amount, or copayment, for each doctor or emergency room visit and for prescription drugs, rather than paying the provider in full and obtaining a portion of the reimbursement later. Members must use the HMO's network of providers, which may include the doctors, pharmacies and hospitals under contract with that particular HMO.
- **Point of Service plans (POS)** - In a POS plan, insured members may choose, at the point of service, whether to receive care from a physician within the plan's network or to go out of the network for services. The POS plan provides less coverage for health care expenses provided outside the network than for expenses incurred within the network. Also, the POS plan will usually require you to pay deductibles and coinsurance costs for medical care received out of network.

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Limited Benefit Coverage Plans

Limited benefit health plans are insurance products with reduced benefits intended to supplement comprehensive health insurance plans, not to be an alternative to them. You may have seen these types of plans marketed as Accident Policy, Cancer Only, Specific Disease or Heart Policies, Hospital Cash or Indemnity plans. They may also be Discounted Plans such as Pharmacy, Dental or Medical Clinic Memberships. **These plans are not considered ACA compliant which could result in you paying additional out-of-pocket expenses for uncovered medical services and a fee or tax if you do not have a comprehensive health insurance plan as your primary plan.**

Limited benefit health insurance plans are not typically required to provide the same level of coverage, so they cover fewer types of medical services and expenses than a comprehensive policy. These plans typically pay you a flat amount for a specific service, covered item or covered disease or giving you a discount for services, leaving you the rest of the bill to pay yourself. A limited benefit plan may limit the amount of coverage the company will pay per episode of illness or per day, sometimes as low as $50 to $5,000 (not counting co-insurance and deductibles paid out-of-pocket by you). These policies also provide limited surgical, preventative care, testing and emergency benefits upon receipt of the billing. And with low maximum benefit limits called “caps,” it may be poss ble for you to reach your cap quickly, leaving you responsible for the balance of the bill. Discounted plans still leave you paying for the services yourself.

Buyer beware when purchasing Limited Benefit Plans – understand what you are purchasing!

Click here for more information on Limited Benefit Coverage Plans

- **Accident Only:** Pays only when you are treated for accidental injury or if an accident causes death.
- **Disability Income:** Pays a fixed amount for a specified period of time when you are unable to work because of an accident or illness.
- **Hospital Indemnity:** Pays a flat amount (such as $100 per day) when you are hospitalized.
- **Long-Term Care:** Pays to take care of you for an extended time in a nursing home or your own home. For more information, visit www.longtermcare.gov. For information about the Oklahoma Long Term Care Partnership, visit: www.okltcpartnership.org
- **Medicare Supplement:** Pays some medical expenses not paid by Medicare. (See the Choosing a Medigap Policy)
- **Special Need:** Pays for health care not covered by typical major medical policies (for example, dental or vision care).
- **Specific Disease:** Pays only for treatment for a disease or condition specifically named in the policy such as cancer.
- **Home Health Care:** Pays for health care delivered to you in your home.

Other types of plans:

- **Discount Plans** - These plans are not considered ACA compliant which could result in you paying a fee or tax if you do not have a comprehensive health insurance plan as your primary plan. - Medical Discount Plans, Prescription Discount Plans, Dental Discount Plans, and Vision Discount Plans are programs where a consumer pays a fee to join a plan in return for discounts on products and services from participating vendors and providers. Often, members who join these plans are issued a card similar to an insurance card identifying them as a member. However, these plans are NOT insurance. Buyer beware!

How do I Purchase Health Coverage?

Individual vs. Group Coverage

There are two basic ways to buy health coverage: as an individual or through a group. How you buy health coverage affects your rights and responsibilities.

Individual Coverage

- You may buy individual health insurance either outside of the Oklahoma federal exchange through an agent, broker or directly from the insurance carrier or from the Oklahoma federal exchange at www.healthcare.gov. When you buy individual health insurance, you contract directly with a health carrier just l ke insuring your home or car.
- You are the policyholder. However, HMOs call the contract-holder (the person in whose name the contract is written) a **subscriber**, member or enrollee.
- Your individual policy can cover your entire family (or only certain individuals in your family, like child/ren only, or the one adult who needs coverage) and each covered family member would be an **insured**.
- Any premium increase affects everyone who has the same kind of policy. Insurance carriers can only rate applicants for insurance on age, tobacco use, zip code and family composition.
- Unless you have made false statements on your application, filed fraudulent claims or failed to pay your premiums on time, the company cannot cancel your policy because of your health, pre-existing conditions or claims.
- Coverage must include specific minimum benefits as stated by the Affordable Care Act and Oklahoma state law
- Rates for fully-insured individual policies are regulated by the Oklahoma Insurance Department. However, individual policies sold in the federal exchange or SHOP are also regulated by CMS.
- The policy must include specific minimum essential benefits required by federal and Oklahoma state law.

Group Coverage

Group Coverage can be purchased outside of the exchange through an agent or broker or directly from the carrier. Small employer groups (until the end of 2015, those with 50 or fewer employees) can purchase through an exchange called the SHOP.

A group insurance policy may cover two to thousands of people, but it is still only one policy.

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- Your employer or association is the master policyholder; you and your fellow group members are certificate holders.
- Each family member covered under your certificate is an insured.
- The master policyholder (Employer or Association) negotiates the terms of a group policy with the insurance company.

The **master policyholder** can:

- Reduce or change the benefits and coverage (some exceptions apply to Grandfathered Plans), including determining to cover employees and children only and to cover or exclude spouses.
- Increase your share of the premium (some exceptions apply to Grandfathered Plans),
- Switch to another insurance company, or
- Stop providing any coverage!

In a group contract

- Rates for fully-insured employer groups are negotiable with the insurance carrier and are regulated by the Oklahoma Insurance Department. However, fully-insured group plans in the federal exchange or SHOP are regulated by CMS. Self-insured large group plans are regulated by the Department of Labor.
- The contract must include specific minimum benefits required by federal and Oklahoma state law —other benefits are negotiated by the master policyholder.
- The master policyholder does not need consent of certificate holders to change companies or policies, cancel the policy or agree to new premiums or benefits.

Large and small employer group contracts

- May have more generous benefits.
- Cannot reject an application because of health as long as the application is made during the employer's elig bility period or Open Enrollment. Currently in Oklahoma, large employer groups are defined as having 51 or more employees. Small employer groups are defined as having 2 through 50 employees.
- In late 2016 in the Federal exchange, large groups will be 100 or more.

Other ways you can be covered for Health Care is through a government sponsored program like Medicare, SoonerCare (Medicaid) or VA, etc.

Medicare

SoonerCare

VA

Other Policy Information

What Expenses will I have In Addition to My Premium?

- **Deductibles:** This is the amount of covered health care expenses that must be paid for by the insured before the insurance company will begin paying. Choose deduct bles that you can afford to pay should you need to use your insurance.
- **Co-Insurance:** This is the amount stated in the policy that is the insured's portion of the claim. For instance, the insurance company may pay 60%, 70%, 80% or 90% of the claim and the insured's share or co-insurance is 40%, 30%, 20% or 10% of the claim. You will pay the co-insurance amount in addition to the deductible. Once your deduct ble and coinsurance equal your maximum out-of-pocket, then your plan will pay 100%. The individual and family will have a maximum out of pocket amount for the plan they choose.
- **Co-Payments:** Some policies provide for a set amount paid by the insured for a particular service, usually an office visit, out-patient visit or hospital admission. In that case, the insured pays their co-pay for the visit and the insurer pays the rest of the bill. Amounts you pay for co-payments may or may not go toward the deductible, depending on the policy.

ACA compliant policies have maximum out-of-pocket limits and unlimited lifetime benefits which limits your liability or exposure (how much of the expenses you have to pay yourself). However, out-of-network charges, except in emergency situations, are your responsibility and you may be balanced billed so you must read your policies very carefully and know that your provider is in network before using their services.

How Do I let the Insurance Company Know When I Have a Claim?

When you use an In-Network provider, your provider will file the claim directly with your insurance carrier. You will receive an Explanation of Benefits of how that bill was paid and what your responsibility is, if any. If there is a dispute, contact your insurance carrier customer service department for a resolution, first. Ask for a resolution time frame. If not completed by that time and the explanation seems unreasonable, contact Consumer Assistance at the Oklahoma Insurance Department for help or assistance in appealing.

If your treatment bill has been denied by your insurance carrier, follow these steps to begin the appeal process:

- For policies bought on the Exchange:

EXHIBIT 11

https://www.healthcare.gov/appeal-insurance-company-decision/appeals/

https://www.healthcare.gov/appeal-insurance-company-decision/internal-appeals/

https://www.healthcare.gov/appeal-insurance-company-decision/external-review/

- For policies bought off the Exchange:

  Please refer to the *How To Appeal* sheet enclosed with your Explanation of Benefits received from your insurance carrier on your denied services. For further help, contact your insurance carrier Customer Service Helpline or the Oklahoma Insurance Department Consumer Assistance Department.

Can an Insurance Company Exclude Pre-Existing Conditions?

With the passage of the Affordable Care Act in 2010, eligible children could not be denied insurance coverage due to poor health or prior treatments and beginning January 1, 2014, all eligible persons applying for insurance could not be denied coverage due to poor health or prior treatments.

Click here to see how pre-existing conditions are now protected. This provision applies to policies sold on and off the exchange.

What Happens If I am Late With My Premium Payment?

If you bought a policy on the federal health exchange and you are receiving premium tax credits, you have certain protections when you are late paying your premium. Please contact www.healthcare.gov at 1-800-318-2596.

If you bought a policy outside of the federal health exchange you should contact the insurance carrier's customer service department who will give you instructions and your options.

- The insurance policy must include a grace period during which the policy must continue to be in force. The length of time for the grace period depends on the frequency of premium payments. If the premium is paid on an annual basis, the grace period cannot be less than 31 days. If the premium is due on a weekly basis, the grace period cannot be less than 7 days and not less than 10 days for premiums due on a monthly basis.

Can I Cancel My Policy?

If you have a policy through the federal health exchange, please click here.

If you have a policy outside of the federal exchange, contact your insurance agent or broker who sold you the policy or your insurance carrier's customer service department who will give you instructions and your options.

Can I Get My Policy Back If It Gets Canceled?

You have certain rights and protections both inside and outside of the exchange. However, when an insurance carrier leaves the marketplace, you must follow the instructions you receive from your insurance carrier and take notice of your deadlines to take action.

https://www.healthcare.gov/health-care-law-protections/cancellations/

https://www.healthcare.gov/current-plan-changed-or-cancelled/

Is My Family Included in My Policy?

You have the option of covering your entire family or not at the time of application or during Open Enrollment.. Read the policy and the schedule page to determine who is insured under the policy.

What Are My Benefit Limits?

You will want to refer to your Summary of Benefits and or Policy for your out of pocket limits. Policies can no longer have annual or lifetime limits for essential health benefits. For policies bought through the federal health exchange, please click on the following link:

https://www.healthcare.gov/health-care-law-protections/lifetime-and-yearly-limits/

- Learn more about Employer Health Benefit Plans (ERISA)
- Click here for a glossary of Health Insurance-related terms
- Click here for information regarding COBRA

Subscribe By RSS

EXHIBIT 11

2017 WL 3573829
Only the Westlaw citation is currently available.
United States District Court,
W.D. Oklahoma.

Brittany MARTIN, Plaintiff,
v.
HEALTH CARE SERVICE CORPORATION, a mutual legal reserve company, d/b/a Blue Cross and Blue Shield of Oklahoma, and Rocky Mountain Holdings, L.L.C., a Delaware limited liability company, Defendants.

Case No. CIV-16-1269-C
|
Signed 08/17/2017

Attorneys and Law Firms

Michael T. Torrone, Ryan H. Olsen, Thomas J. McGeady, Logan & Lowry, Vinita, OK, for Plaintiff.

Gregory T. Metcalfe, John M. Krattiger, Gable & Gotwals, Oklahoma City, OK, for Defendants.

Opinion

MEMORANDUM OPINION AND ORDER

ROBIN J. CAUTHRON, United States District Judge

***1** Now before the Court is Defendant Rocky Mountain Holdings, L.L.C.'s ("RMH") Motion for Summary Judgment (Dkt. No. 28); Plaintiff's Motion to Amend the Complaint (Dkt. No. 29); and Plaintiff's Motion to Amend the Scheduling Order (Dkt. No. 30). Each Motion was fully briefed and is now at issue. Due to the nature of the facts, the Court will dispose of all three motions herein.

I. Background

On October 4, 2014, Plaintiff Brittany Martin went into early labor and her doctor in Enid, Oklahoma ordered an emergency air transfer for Plaintiff to go to another care center with neonatal intensive care availability. RMH provided the emergency air transfer for Plaintiff to Integris Baptist Medical Center in Oklahoma City, Oklahoma. RMH billed Plaintiff $42,604.56 for the air transfer. Plaintiff's insurer, Defendant Health Care Service Corporation d/b/a Blue Cross and Blue Shield of Oklahoma ("BCBS") paid $6,902.51, leaving a balance of $35,702.05. RMH initially sought the balance from Plaintiff, who then filed the present suit, seeking declaratory judgment against RMH that she was not liable for the billed amount and that BCBS's insurance contract violated applicable law. Plaintiff also brought claims of breach of contract, bad faith, and fraud and misrepresentation against BCBS.

Nearly two years after Plaintiff's air transfer, RMH and BCBS entered into a new rate agreement and decided to apply the agreement retroactively to Plaintiff's bill, leaving the current balance at zero. RMH represents it no longer seeks payment from Plaintiff or BCBS. Plaintiff states she has not received a release of balance nor has BCBS provided an explanation of benefits. RMH filed a Motion for Summary Judgment, arguing Plaintiff's claim for declaratory judgment is moot. Plaintiff argues the claim is not moot and seeks leave to amend the Complaint and Scheduling Order to add class certification and make two other factual changes.

II. RMH's Motion for Summary Judgment

The standard for summary judgment is well established. Summary judgment may only be granted if the evidence of record shows "there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a). The movant bears the initial burden of demonstrating the absence of material fact requiring judgment as a matter of law. Celotex Corp. v. Catrett, 477 U.S. 317, 322-23, 106 S.Ct. 2548, 91 L.Ed.2d 265 (1986). A fact is material if it is essential to the proper disposition of the claim. Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 248, 106 S.Ct. 2505, 91 L.Ed.2d 202 (1986). If the movant carries this initial burden, the nonmovant must then set forth specific facts outside the pleadings and admissible into evidence which would convince a rational trier of fact to find for the nonmovant. Fed. R. Civ. P. 56(c). All facts and reasonable inferences therefrom are construed in the light most favorable to the nonmoving party. Matsushita Elec. Indus. Co. v. Zenith Radio Corp., 475 U.S. 574, 587, 106 S.Ct. 1348, 89 L.Ed.2d 538 (1986).

Plaintiff seeks a declaratory judgment against RMH, but the Court only has jurisdiction over the claim if a "case of actual controversy" is present. 28 U.S.C. § 2201(a). An actual controversy is "definite and concrete, touching the legal relations of parties having adverse legal interests." Aetna Life Ins. Co. of Hartford, Conn. v. Haworth, 300 U.S. 227, 240-41, 57 S.Ct. 461, 81 L.Ed. 617 (1937) (citations omitted). There is no actual controversy if a claim is moot. To determine mootness in a declaratory judgment case, a court must "look [ ] to whether the requested relief will actually alter the future conduct of the named parties." Schell v. OXY USA Inc., 814 F.3d 1107, 1114 (10th Cir. 2016), cert. denied, U.S. , 137 S.Ct. 376, 196 L.Ed.2d 293 (2016), and cert. denied, U.S. , 137 S.Ct. 446, 196 L.Ed.2d 328 (2016) (citations omitted). "[A] federal court [must] refrain from deciding [the claim] if events have so transpired that the decision will neither presently affect the parties' rights nor have a more-than-speculative chance of affecting them in the future." Id. (citations and internal quotation marks omitted).

***2** RMH's Motion for Summary Judgment argues the declaratory judgment claim is moot and the Court has no jurisdiction over it. As the issue stands today, Plaintiff owes nothing to RMH for the emergency air transfer services it rendered in 2014.

Plaintiff claims there are conflicting dates regarding when Defendants actually told her there was no balance. Even taking this as true, the fact remains that Plaintiff owes nothing; there is no controversy. Plaintiff's arguments regarding public policy and her demands for an official release of the balance or judicial determination as a matter of law that she owes nothing are not persuasive. Rather than an intentional mooting of Plaintiff's claim to manipulate the Court's jurisdiction, the Court views the outcome of Defendants' decision to apply the new rates retroactively as a public benefit. This is an outcome similar to bargains struck during settlement negotiations, but in this case, Plaintiff received the benefit of a zero-balance bill without participating in settlement negotiations.

Plaintiff argues that if the Court finds the declaratory judgment claim is moot, judicial estoppel requires a determination that Plaintiff is the prevailing party. As defined by Plaintiff, a prevailing party is the litigant that succeeds upon its merits. Hanrahan v. Hampton, 446 U.S. 754, 758, 100 S.Ct. 1987, 64 L.Ed.2d 670 (1980) (per curiam) (interpreting availability of attorney fees in civil rights case). Here, Plaintiff's moot claim has not reached a decision on its merits, nor does judicial estoppel fit the facts of this case. The doctrine focuses on parties employing inconsistent positions in separate legal actions to gain an unfair advantage and seek conflicting rulings. See generally 18B Wright & A. Miller Fed. Prac. & Proc. Juris. § 4477 (2d ed.). Even if this case were eligible for judicial estoppel, Plaintiff cannot meet the second estoppel factor set out by the Tenth Circuit. Neither Defendant has persuaded the Court to accept an earlier position that is different from the current position-i.e., Defendants agreed to apply the fee arrangement retroactively to Plaintiff's bill. See BancInsure, Inc. v. F.D.I.C., 796 F.3d 1226, 1240 (10th Cir. 2015) (citation and internal quotation marks omitted) (listing factors and noting judicial estoppel should be applied narrowly and cautiously). While Defendants asserted a different position regarding the bill in the pleadings-i.e., the Plaintiff owed a balance, the present Motion submits the first dispositive issues considered by the Court in this case.

Therefore, judicial estoppel does not declare Plaintiff the prevailing party. The Court was also unable to locate authority for naming a prevailing party when there is a moot declaratory action. See Schell, 814 F.3d at 1127-28 (finding no independent basis within the Federal Declaratory Judgment Act to award attorney fees). The Court has reviewed Plaintiff's cross motion for summary judgment on this issue and has determined it raises no issue not addressed or precluded by this decision. Accordingly, Rocky Mountain Holding's Motion for Summary Judgment (Dkt. No. 53) is granted and Plaintiff's Motion for Summary Judgment against RMH (Dkt. No. 46) is stricken as moot. Because the only claim against RMH is moot, RMH is terminated as a party to this action.

III. Plaintiff's Motion to Amend Complaint

***3** Plaintiff filed her request for leave to amend the Complaint on July 14th when the deadline for motions to amend pleadings was February 1st and discovery was scheduled to end August 1st. She states the reason for this request is new information, that is, the fact that RMH was no longer seeking payment from her came to light in RMH's Motion for Summary Judgment. Plaintiff argues the "second and undisclosed payment on Plaintiff's

account with RMH after commencement of this suit" was in direct contradiction to BCBS's expert witness report. (Mot. to Amed Compl., Dkt. No. 29, p. 3.) Plaintiff represents she was diligent in meeting scheduling deadlines and no party had conducted depositions.

RMH objected on the basis that it argues the claim for declaratory judgment against it is moot and this was previously disclosed in its initial disclosures which state "RMH is not seeking damages and seeks no additional payments from Plaintiff or [BCBS] based on information provided by the co-defendant." (Initial Disclosures, Dkt. No. 28-2, p. 2.) The arguments regarding this information and other facts in the briefs break down into little more than bickering regarding communications during the discovery process. Plaintiff's counsel should have called RMH's counsel if the language contained in the initial disclosure was unclear; likewise, RMH's counsel should have made an effort to construct a clearer statement.

In its response, BCBS also has a laundry list of complaints regarding Plaintiff's actions during discovery, to which Plaintiff offers explanations and counterarguments.[*] BCBS argues the proposed amendments would essentially start the case from scratch, and the Court agrees. Plaintiff either knew or should have known of the facts she qualifies as new information in RMH's motion. The Court finds Plaintiff has not demonstrated good cause for such a substantial amendment to the Complaint and a discovery re-do. The amendment request is long past due and allowing it would cause severe prejudice to the Defendants and undue delay in the case. Accordingly, Plaintiff's request to amend the Complaint is denied.

IV. Plaintiff's Motion to Amend Scheduling Order

Plaintiff requests leave to amend the Scheduling Order whether or not the request to amend the Complaint is granted. Plaintiff points to late submissions by BCBS, issues with the parties agreeing on a protective order, and failed settlement negotiations as matters of delay requiring an amendment to the Scheduling Order. In turn, Defendants attempt to lay blame at Plaintiff's feet. The Court will not sort out each grievance and finds that all three parties share fault in the delays presented.

The Court will extend the discovery deadline not for good cause, but because this Order moots the claim against RMH and the remaining parties may need to conduct depositions. A separate Amended Scheduling Order shall issue. The parties are advised that no further extensions will be granted without good cause. In light of this decision and the Court's requirement that counsel renew and improve their efforts to communicate, BCBS's Motion to Strike (Dkt. No. 58) is stricken and the parties will meet and confer or teleconference regarding the issues before the Court will address the problem. The Amended Scheduling Order does not extend the witness list deadline, but a motion to amend the current witness lists would be considered. All other pending motions will proceed with normal briefing procedure.

CONCLUSION

***4** For the reasons set forth herein, Defendant Rocky Mountain Holdings, LLC's Motion for Summary Judgment (Dkt. No. 28) is GRANTED. The claim against Defendant is MOOT. Plaintiff's Motion to Amend the Complaint (Dkt. No. 29) is DENIED and Plaintiff's Motion to Amend the Scheduling Order (Dkt. No. 30) is GRANTED in part and DENIED in part. A separate Amended Scheduling Order shall issue. Plaintiff's Motion for Summary Judgment against Rocky Mountain Holdings (Dkt. No. 46) is STRICKEN as moot and Defendant Health Care Service Corporation's Motion to Strike (Dkt. No. 58) is STRICKEN.

IT IS SO ORDERED this 17th day of August, 2017.

All Citations

Slip Copy, 2017 WL 3573829

Footnotes

[*] The parties are strongly encouraged to work harder at cooperating and responding to communications from opposing counsel. The Court will not issue sanctions sua sponte at this time, but will reconsider this decision if the current behavior continues. Many of the factual issues presented should have been resolved amongst the parties rather than generating unnecessary and lengthy discussion in the briefs.

2017 WL 3573829

End of Document

JS 44 (Rev. 06/17)

CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. *(SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)*

I. (a) PLAINTIFFS

Christina and Jeffrey Terry, husband and wife, each individually and on behalf of their minor child, G.Terry, and on behalf of all others similarly

(b) County of Residence of First Listed Plaintiff
(EXCEPT IN U.S. PLAINTIFF CASES)

(c) Attorneys *(Firm Name, Address, and Telephone Number)*
Edward L. White
Kerry D. Green
829 East 33rd, Edmond, Oklahoma 73013

DEFENDANTS

Health Care Service Corporation, a mutual legal reserve company, d/b/a Blue Cross Blue Shield of Oklahoma

County of Residence of First Listed Defendant
(IN U.S. PLAINTIFF CASES ONLY)

NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.

Attorneys *(If Known)*

II. BASIS OF JURISDICTION *(Place an "X" in One Box Only)*

- ☐ 1 U.S. Government Plaintiff
- ☒ 3 Federal Question *(U.S. Government Not a Party)*
- ☐ 2 U.S. Government Defendant
- ☐ 4 Diversity *(Indicate Citizenship of Parties in Item III)*

III. CITIZENSHIP OF PRINCIPAL PARTIES *(Place an "X" in One Box for Plaintiff and One Box for Defendant)*
(For Diversity Cases Only)

	PTF	DEF		PTF	DEF
Citizen of This State	☒ 1	☐ 1	Incorporated *or* Principal Place of Business In This State	☐ 4	☐ 4
Citizen of Another State	☐ 2	☐ 2	Incorporated *and* Principal Place of Business In Another State	☐ 5	☒ 5
Citizen or Subject of a Foreign Country	☐ 3	☐ 3	Foreign Nation	☐ 6	☐ 6

IV. NATURE OF SUIT *(Place an "X" in One Box Only)*

Click here for: Nature of Suit Code Descriptions.

CONTRACT
- ☐ 110 Insurance
- ☐ 120 Marine
- ☐ 130 Miller Act
- ☐ 140 Negotiable Instrument
- ☐ 150 Recovery of Overpayment & Enforcement of Judgment
- ☐ 151 Medicare Act
- ☐ 152 Recovery of Defaulted Student Loans (Excludes Veterans)
- ☐ 153 Recovery of Overpayment of Veteran's Benefits
- ☐ 160 Stockholders' Suits
- ☒ 190 Other Contract
- ☐ 195 Contract Product Liability
- ☐ 196 Franchise

REAL PROPERTY
- ☐ 210 Land Condemnation
- ☐ 220 Foreclosure
- ☐ 230 Rent Lease & Ejectment
- ☐ 240 Torts to Land
- ☐ 245 Tort Product Liability
- ☐ 290 All Other Real Property

TORTS

PERSONAL INJURY
- ☐ 310 Airplane
- ☐ 315 Airplane Product Liability
- ☐ 320 Assault, Libel & Slander
- ☐ 330 Federal Employers' Liability
- ☐ 340 Marine
- ☐ 345 Marine Product Liability
- ☐ 350 Motor Vehicle
- ☐ 355 Motor Vehicle Product Liability
- ☐ 360 Other Personal Injury
- ☐ 362 Personal Injury - Medical Malpractice

PERSONAL INJURY
- ☐ 365 Personal Injury - Product Liability
- ☐ 367 Health Care/ Pharmaceutical Personal Injury Product Liability
- ☐ 368 Asbestos Personal Injury Product Liability

PERSONAL PROPERTY
- ☐ 370 Other Fraud
- ☐ 371 Truth in Lending
- ☐ 380 Other Personal Property Damage
- ☐ 385 Property Damage Product Liability

CIVIL RIGHTS
- ☐ 440 Other Civil Rights
- ☐ 441 Voting
- ☐ 442 Employment
- ☐ 443 Housing/ Accommodations
- ☐ 445 Amer. w/Disabilities - Employment
- ☐ 446 Amer. w/Disabilities - Other
- ☐ 448 Education

PRISONER PETITIONS

Habeas Corpus:
- ☐ 463 Alien Detainee
- ☐ 510 Motions to Vacate Sentence
- ☐ 530 General
- ☐ 535 Death Penalty

Other:
- ☐ 540 Mandamus & Other
- ☐ 550 Civil Rights
- ☐ 555 Prison Condition
- ☐ 560 Civil Detainee - Conditions of Confinement

FORFEITURE/PENALTY
- ☐ 625 Drug Related Seizure of Property 21 USC 881
- ☐ 690 Other

LABOR
- ☐ 710 Fair Labor Standards Act
- ☐ 720 Labor/Management Relations
- ☐ 740 Railway Labor Act
- ☐ 751 Family and Medical Leave Act
- ☐ 790 Other Labor Litigation
- ☐ 791 Employee Retirement Income Security Act

IMMIGRATION
- ☐ 462 Naturalization Application
- ☐ 465 Other Immigration Actions

BANKRUPTCY
- ☐ 422 Appeal 28 USC 158
- ☐ 423 Withdrawal 28 USC 157

PROPERTY RIGHTS
- ☐ 820 Copyrights
- ☐ 830 Patent
- ☐ 835 Patent - Abbreviated New Drug Application
- ☐ 840 Trademark

SOCIAL SECURITY
- ☐ 861 HIA (1395ff)
- ☐ 862 Black Lung (923)
- ☐ 863 DIWC/DIWW (405(g))
- ☐ 864 SSID Title XVI
- ☐ 865 RSI (405(g))

FEDERAL TAX SUITS
- ☐ 870 Taxes (U.S. Plaintiff or Defendant)
- ☐ 871 IRS—Third Party 26 USC 7609

OTHER STATUTES
- ☐ 375 False Claims Act
- ☐ 376 Qui Tam (31 USC 3729(a))
- ☐ 400 State Reapportionment
- ☐ 410 Antitrust
- ☐ 430 Banks and Banking
- ☐ 450 Commerce
- ☐ 460 Deportation
- ☐ 470 Racketeer Influenced and Corrupt Organizations
- ☐ 480 Consumer Credit
- ☐ 490 Cable/Sat TV
- ☐ 850 Securities/Commodities/ Exchange
- ☐ 890 Other Statutory Actions
- ☐ 891 Agricultural Acts
- ☐ 893 Environmental Matters
- ☐ 895 Freedom of Information Act
- ☐ 896 Arbitration
- ☐ 899 Administrative Procedure Act/Review or Appeal of Agency Decision
- ☐ 950 Constitutionality of State Statutes

V. ORIGIN *(Place an "X" in One Box Only)*

☒ 1 Original Proceeding ☐ 2 Removed from State Court ☐ 3 Remanded from Appellate Court ☐ 4 Reinstated or Reopened ☐ 5 Transferred from Another District *(specify)* ☐ 6 Multidistrict Litigation - Transfer ☐ 8 Multidistrict Litigation - Direct File

VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing *(Do not cite jurisdictional statutes unless diversity)*:
Fed.R.Civ.P.23

Brief description of cause:
Breach of Contract

VII. REQUESTED IN COMPLAINT:

☐ CHECK IF THIS IS A CLASS ACTION UNDER RULE 23, F.R.Cv.P.

DEMAND $

CHECK YES only if demanded in complaint:
JURY DEMAND: ☐ Yes ☐ No

VIII. RELATED CASE(S) IF ANY

(See instructions)

JUDGE DOCKET NUMBER

DATE 27 Apr 2018

SIGNATURE OF ATTORNEY OF RECORD Edward L. White

FOR OFFICE USE ONLY

RECEIPT # AMOUNT APPLYING IFP JUDGE MAG. JUDGE

ClassAction.org