OPEH&W Health Plan
www.opehw.com

DIAMOND
CHOICE
HEALTH COVERAGE

BENEFIT BOOK
2025-2026 Plan Year

Last Revised on 3/18/2025

This Edition Supersedes All Past Editions

Disclaimer: This Benefit Book may be updated from time to time. Please check the Plan's Website above or contact the Plan Administrators office at **800.468.5744** to ensure you have all applicable Amendments and update notifications.

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About the Plan

The Oklahoma Public Employees Health and Welfare Plan is established and maintained for the purpose of providing a plan of comprehensive healthcare benefits and other benefits in the event of Illness, Accident, disability, death or the like. The "Plan" is provided to you by your Employer through an Inter-Local Governmental Agreement. This Agreement allows your Employer to cooperate with other Participating Governmental Agencies in a joint effort to provide mutually-desired Benefits at a competitive cost.

The Inter-Local Governmental Agreement and the Plan are controlled by a Board of Review representing the Participating Governmental Agencies in the Agreement. These individuals also serve as Trustees monitoring the Plan, funding accounts, and entering into service agreements with entities necessary to run the everyday affairs of the Plan.

Under the terms of the Inter-Local Governmental Agreement, each Employer who enters into the Agreement is responsible for the payment of its prorated share of Plan funding based on the number of its Employees participating in the Plan. Each Employer will determine the amount it will charge its Employees, for his/her participation, and will payroll deduct the Employees share of the cost, if any.

All funds contributed by the Employer and its Employees in the Plan are paid to and maintained by the Trust Fund identified in the Inter-Local Governmental Agreement. The Trust Fund will be operated by the Trustees according to a Trust Agreement established by the Inter-Local Governmental Agreement.

The Trustees contract with a Plan Administrator who has the discretion and authority to control and manage the operation of the Plan. For medical, prescription drug, and dental care, the Plan is self-insured and assumes financial responsibility for paying claims out of the Trust Fund. The Plan then contracts with Claims Administrators who receive and process claims for Benefits under the terms of the Plan. The Claims Administrators provide administrative claim payment services only and do not assume any financial risk or obligation with respect to claims. The Plan also contracts with vendors to provide vision care and life insurance benefits, whereas these vendors assume all financial risk and obligation with respect to vision and life claims.

Who is the Plan Administrator and how do I contact them?

The Plan is administered by **McElroy & Associates, Inc**. You may contact them by any of the following methods:

Address: **3851 E. Tuxedo Blvd, Suite C**
Bartlesville, OK 74006

Toll Free #: **800.468.5744**

Local #: **918.333.3045**

FAX #: **918.333.5220**

Website: **www.opehw.com**

For contact information of the Plan's Board of Review and Trustees, please contact the Plan Administrator's office.

Will there ever be any changes to this Benefit Book?

The Plan reserves the right to make changes, also called “Amendments”, to this document as needed. The Amendment shall change the provisions or Benefits of the Plan. Examples of such changes might be federal or state law changes, Plan Benefit changes or changes required to meet the special needs of your Employer. The up-to-date version of this Benefit Book can always be found on the Plan’s website at **www.opehw.com**.

Purpose of this Benefit Book

The purpose of this Benefit Book is to provide you and your applicable family members with information you must know about your coverage, including:

- Who qualifies for the Plan
- What’s covered under the Plan
- What’s excluded from coverage
- Coverage limitations
- How to use your coverage
- How claims get paid
- Your rights and responsibilities
- Glossary of Terms used in this Benefit Book

How to Interpret this Benefit Book

- Please note that the terms "you" and "your" used throughout this Benefit Book refer to you (the Eligible Employee) and to all your Eligible Dependents, except where otherwise indicated.

- Many of the terms (words) used throughout this Benefit Book are capitalized. These terms are important to understanding your Benefits and can be found in the “**Glossary of Terms**” section located at the back of this book.

- This Benefit Book along with the Inter-Local Governmental Agreement are the official Plan documents. Copies of these documents are available from the Plan Administrator. You may examine them at any time during normal working hours.

- The information provided in this Benefit Book is a summary of the Benefits, conditions, limitations, and Exclusions of the Plan. It should not be considered an all-inclusive listing.

- This Plan is not governed by the **E**mployee **R**etirement **I**ncome **S**ecurity **A**ct of 1974 (**ERISA**).

Prescription Drug Coverage as good as Medicare’s

Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

The OPEH&W Plan has determined that the prescription drug coverage offered by the OPEH&W Plan is, on average for all Plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered creditable coverage. Because your coverage under the Plan is creditable coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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Plan & Vendor Contact Information

OPEH&W Plan Administration Office

Customer Service:	**800.468.5744**
FAX:	**918.333.5220**
Website:	**www.opehw.com**
HEART Enrollment Website:	**www.opehwheart.com**

Medical and Dental Coverage

Vendor:	**BlueCross BlueShield of Oklahoma**	
Website:	**www.bcbsok.com**	
Medical Customer Service:	**800.313.5162**	**Group# YN9727**
Dental Customer Service:	**888.381.9727**	**Group# DN9727**
24/7 Nurseline:	**800.851.0407**	
MDLive:	**888.970.4081** **or** **https://members.mdlive.com/bcbsok**	

Prescription Drug Coverage

Vendor:	**Express Scripts**
Website:	**www.express-scripts.com**
Customer Service/Mail Order:	**855.315.2460**
Accredo Specialty Pharmacy:	**800.803.2523**

Vision Coverage

Vendor:	**VSP (Vision Service Plan)**
Website:	**www.vsp.com**
Customer Service:	**800.877.7195**

Life Coverage

Vendor:	**MetLife**
Website:	**www.metlife.com**
Customer Service:	**866-492-6983**

Eligibility, Enrollment, Changes & Terminations

What you can find in this section:

- **How and when you become eligible for coverage under the Plan**
- **How and when your coverage becomes effective**
- **When your coverage ends**
- **Who is considered an Eligible Dependent**
- **How and when your Eligible Dependents coverage becomes effective**
- **When your Dependent coverage ends**
- **When you can add or make changes to your coverage**
- **Coverage for Surviving Dependents**
- **Retiree Eligibility and coverage options**
- **COBRA Continuation Coverage**

Employees

Who qualifies as an Eligible Employee for Benefits?

You are an Eligible Employee if you are a full-time Employee of an Employer which is a Participating Governmental Agency of the Inter-Local Governmental Agreement or other Plan-approved entity.

A full-time Employee is an Employee who, at a location established by the Employer, is actively working a full scheduled work week of not less than **20** hours in the conduct of the business of the Employer and not classified as a part-time, temporary or seasonal Employee. However, each Employer may require a higher minimum number of hours to be considered a full-time Employee. You will need to check with your Employer to find out their minimum requirements.

A person elected by popular vote, including elected officials and board members of a Participating Governmental Agency, will be considered an Eligible Employee during the persons tenure in office.

Education Employees must be actively working a full scheduled workweek of not less than **20** hours or be regularly scheduled to work a minimum of **1,000** hours per year.

When does coverage start for an Eligible Employee?

Each Employer group will choose a Waiting Period for their Employees. A Waiting period is the time period between when you first become an Eligible Employee and when your coverage actually begins. Following are the different Waiting Period options from which the Employer can choose and the Effective Date on which your coverage would begin. Check with your Employer to find out which Waiting Period applies to you.

- **Date of Hire:** If your full-time employment date is on the first day of a month, your coverage will be effective that same day. If your full-time employment date is after the first day of the month, then your Effective date will be the first day of the next month.

  Example: If your full-time employment date is 1/1/2017, then your Effective date will also be 1/1/2017. If your full-time employment date is 1/9/2017, then your Effective date will be 2/1/2017.

- **First Day of Next Month**: Your Effective date will be the first day of the next month following your full-time employment date.

  Example: If your full-time employment date is 1/1/2017, then your Effective Date will be 2/1/2017. If your full-time employment date is 1/9/2017, then your Effective Date will be 2/1/2017.

- **30 Days Plus First Day of Next Month**: The first day of the next month following **30** days after your full-time employment date, or, the first day of the month if **30** days after your full-time employment date falls on the first day of the month.

  Example: If your full-time employment date is 1/9/2017, then your Effective Date will be 3/1/2017; however, if your full-time employment date is 1/1/2017, then your Effective date will be 2/1/2017.

- **60 Days Plus First Day of Next Month:** The first day of the next month following **60** days after your full-time employment date, or, the first day of the month if **60** days after your full-time employment date falls on the first day of the month.

  Example: If your full-time employment date is 1/9/2017, then your Effective Date will be 4/1/2017; however, if your full-time employment date is 1/1/2017, then your Effective date will be 3/1/2017.

Waiting Period Exceptions:

- **FMLA**: Coverage eligibility is immediate if you are returning from an absence defined under the Family and Medical Leave Act (FMLA), and you were covered prior to the absence.

- **Elected Official**: Elected Officials do not have to satisfy any Waiting Periods. Your benefits will begin on the first day of the month after your tenure begins, unless your tenure begins on the first day of a month, then your coverage will be effective the same day (see Date of Hire rules above).

- **New Entity to the Plan:** If your Employer is initially joining the Plan AND you are an Eligible Employee on the Employer's effective date with the Plan AND you were covered under the Employer's previous Group Health Plan on the day immediately preceding your Employer's effective date with the Plan, then your Effective Date shall be the same as your Employer's effective date with the Plan.

When does Employee coverage end?

Your coverage will automatically terminate on the earliest of the following dates:

- The date the Plan ceases to exist or the date your Employer no longer participates in the Plan;

- The end of the month for which the last contribution payment was received for your coverage, unless you elect COBRA Continuation Coverage or are approved for Temporary Layoff/ Approved Leave of Absence/Disability, or are qualified for leave under the Family and Medical Leave Act (see the "**Temporary Layoff, Approved Leave of Absence, Disability and Family and Medical Leave Act (FMLA)**" section); or

- The date you cease to be an Eligible Employee under the Plan (see the "**COBRA Continuation Coverage"** section).

Dependents

Who qualifies as an Eligible Dependent?

If you are an Eligible Employee and Enroll in the Plan, you may also Enroll your Eligible Dependents according to the following provisions. An Eligible Dependent shall be defined only as the following:

- Your legal spouse (including common law, same or opposite gender);

  - This Plan does recognize common law marriages, however, the Employee must complete and submit an Affidavit of Common Law Marriage and any other required documentation listed on the Affidavit. The completed Affidavit is then subject to approval by the Plan Administrator.

- Your natural child, a stepchild, an eligible foster child, a child placed under a “qualified medical support order”, an adopted child or child Placed for Adoption (including a child for whom you or your spouse is a party in a legal action in which the adoption of the child is sought), **under 26 years of age,** regardless of presence or absence of a child’s financial dependency, residency, student status, employment status, marital status, eligibility for other coverage, or any combination of those factors.

    - A child not listed above who is legally and financially dependent upon the Eligible Employee or spouse is also considered an Eligible Dependent child under the Plan, provided proof of dependency is provided with the child’s enrollment form.

    - Dependent children are eligible for coverage until the end of the month of their **26th** birthday.

    - An unmarried Dependent child who is medically certified as Disabled and dependent upon you or your spouse will continue to be eligible for coverage regardless of age, provided the disability began before the child attained the age of **26** and proof of such disability can be provided upon request.

    - The Plan reserves the right to request verification of a Dependent child’s age, dependency or disability upon initial enrollment and from time to time thereafter.

    - If one Eligible Dependent child is covered, **ALL** Eligible Dependent children must be covered unless the other dependent children are covered under another Group Health Plan or health insurance coverage or are eligible to use Indian or military health service benefits.

    - Adopted Children – Eligibility for coverage is provided to adopted children of Covered Persons as for any natural children, regardless of whether the adoption has become final. The child(ren) must be established as “placed” or “being Placed for Adoption” which means the assumption and retention, as established in adoption proceedings, by a covered person of the legal duty for the total or partial support of a child(ren) to be adopted. The child(ren)’s placement with such person and the responsibility of the Plan terminate whenever the legal duty terminates if prior to completion of adoption.

    - Subject to the Exclusions, conditions and limitations of this Benefit Book, 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 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 an Eligible Dependent child is also an Eligible Employee, such Dependent child may Enroll as an Employee or as an Eligible Dependent child, or both.

When does coverage start for Eligible Dependents?

Your Eligible Dependent(s) coverage will be effective on the latest of:

- Your Effective Date; or
- The date you acquire your first Eligible Dependent; or
- If your Employer is initially joining the Plan AND you are an eligible Employee with Eligible Dependents on the Employer's effective date with the Plan AND your Eligible Dependents were covered under the Employer's previous Group Health Plan on the day immediately preceding your Employer's effective date with the Plan, then your Eligible Dependents Effective Date shall be the same as your Employer's effective date with the Plan.

When does Dependent coverage end?

Dependent coverage will automatically terminate on the earlier of:

- The date your coverage terminates;
- The end of the month for which the last contribution payment was received for your Dependent (family) coverage; or
- The end of the month following the date he/she ceases to qualify as a Dependent.

Coverage can be continued under the same provisions if covered through an Employee's Temporary Layoff, Disability or Approved Leave of Absence or under the Family and Medical Leave Act (FMLA) or through COBRA Continuation Coverage.

Delayed Effective Date for Employee and/or Eligible Dependents

If you apply for coverage and are not Actively at Work on what would be your Effective Date, then the Effective Date will be delayed until the date you are Actively at Work.

This provision shall not apply to an Eligible Employee who was covered under the Employer's previous Group Health Plan on the day immediately preceding the Employer's effective date of coverage with the Plan and your Effective Date is the same as your Employer's or to persons elected by popular vote, including elected officials and board members of a Participating Governmental Agency during the persons' tenure in office.

In no event will your Dependents' coverage become effective prior to your Effective Date.

Temporary Layoff, Approved Leave of Absence, Disability and Family Medical Leave Act (FMLA)

Your full-time, active employment is a condition that determines your eligible status under the Plan. Cessation of Active Work will terminate your eligible status. However, if the cessation of Active Work is due to temporary layoff, approved leave of absence, Disability which prevents you from engaging in any occupation for compensation, profit, or gain, or approved family and medical leave, your eligible status will continue your Benefits for a specified period of time as noted below:

- For Non-Education Employees, benefits can continue during the period of temporary layoff or approved leave of absence but not for longer than **3** months; for Education Employees, benefits can continue during the period of temporary layoff or approved leave of absence but not for longer than **24** months;
- During the period of such Disability, benefits can continue but not for longer than **3** months from the date of original Disability;

- In consideration of various Employers maintaining equality with State of Oklahoma procedures regarding Employees who are Disabled due to a Workers' Compensation Injury or Illness, the Plan will allow the Employee to continue benefits (single or family as warrants) to a maximum of the first of the month following **12** continuous months from the date the Injury or Illness commences the Disability.

- Benefits can continue during the period you qualify under the Family and Medical Leave Act (FMLA) (See your Employer for details). This does not extend the periods defined above.

Please check with your Benefit Coordinator regarding **payment of your premiums** during your period of cessation of active work.

If you don't return to Active Work within the time periods specified above, your coverage will terminate the last day of the month after the specified period of time is exhausted. At that time, if your premiums are paid up-to-date, you may be eligible to continue your coverage under COBRA. See the "**COBRA Continuation Coverage**" section for more information.

If your time period specified above is exhausted thereby terminating your coverage, or your coverage is terminated due to non-payment of your premiums while you are on one of the specified leaves above, and you later return to Active Work as an Eligible Employee, you may be eligible to have your coverage reinstated the first of the month following the date of your return to Active Work. Please check with your Benefit Coordinator to find out if you are eligible.

Eligibility for life insurance benefits may differ from above due to cessation of Active Work. Please see the Life Insurance Certificate for eligibility rules.

Enrollment Periods

Initial Enrollment Period (for newly hired Employees or Newly Eligible Employees)

Once you become an Eligible Employee, you have a **31** day period immediately following the date that you become an Eligible Employee to Enroll yourself and your Eligible Dependents for coverage under the Plan. The date at which an Employee is deemed Eligible is either their date of hire as a full-time Employee, the date they were sworn in to an elected official office or the first day of the month following a month as a Part-Time Employee in which they worked more than 120 hours.

You must complete your enrollment through the Plan's online enrollment system called HEART. If you do not complete your online enrollment within the **31** day period, then you will be ineligible to Enroll for coverage until the Plan's next Renewal Period, or if you experience a Qualifying Event which allows you a Special Enrollment Period. You can access the HEART online enrollment system at **www.opehwheart.com.**

Annual Renewal Period

If you did not Enroll yourself or your Eligible Dependents for coverage under the Plan when first eligible to do so (during your Initial Enrollment Period) or during a Special Enrollment Period, you may apply for coverage during the Plan's Annual Renewal Period.

An Annual Renewal Period will be held each year from **April 1st** to **May 31st** before the beginning of each Plan Year (**July 1st**). Your Annual Renewal must be completed online on the Plan's HEART website at **www.opehwheart.com**. If any other documentation is required, it must be received during this timeframe as well, or coverage will not take effect (example: Common Law Marriage Affidavit, Statement of Health for life insurance, etc.).

During the Annual Renewal Period, you can review any benefit or premium rate changes for the upcoming Plan Year, make changes to your coverage and/or your Dependents' coverage, such as: adding or canceling medical/prescription, dental or vision, or adding or canceling any voluntary (employee paid) benefits, such as Additional Life Coverage. Only the Plan benefits available to your Employer Group will be visible on your page.

Any approved additions, changes or cancellations of coverage made during the Annual Renewal Period will become effective on the first day of the Plan Year (**July 1st**) following the Annual Renewal Period, with the exception of Additional Life Insurance. If you requested changes to Additional Life Insurance amounts AND you were required to complete a Statement of Health, then your requested changes will not be effective until the first day of the month following the date that the Plans' Life Insurance vendor approves your requested amount.

If you don't Enroll yourself or your Eligible Dependents, or make changes to your coverage, during this time, then you will have to wait until the next Annual Renewal Period to apply for coverage or make changes to your coverage, unless you become eligible for a Special Enrollment Period or a Change in Status.

Annual Renewal Period Procedures

1. Once the Annual Renewal Period begins, you can log-on to the Plan's online HEART website at **www.opehwheart.com** to complete your Annual Renewal Period review and make any necessary changes to benefits, contact information, Protected Health Information Authorizations and Life Beneficiary's. If you don't yet have a HEART user account, you must create one in order to access the Annual Renewal Period process. You must have a valid email address that you can access in order to create an account.

2. You can log back in and make multiple changes until the Annual Renewal Period ends on **May 31st**.

3. If you don't complete your online Annual Renewal Period enrollment by **May 31st**, then you will have to wait until the next Annual Renewal Period to enroll or make coverage changes, unless you become eligible for a Special Enrollment Period or Change in Status.

4. Please note that changes to Personal Information, **P**rivate **H**ealth **I**nformation (PHI) Authorizations

or Beneficiary Information can be done anytime throughout the year. Contact your Benefit Coordinator for the appropriate forms, or print them from the Plan's website.

Special Enrollment Period

You should apply for Employee (individual) coverage within **31** days of being first eligible to do so. If you do not, then you will have to wait until the Plan's next Renewal Period to Enroll. However, the Plan includes Special Enrollment Periods during which individuals who previously declined coverage are allowed to Enroll without having to wait until the next Renewal Period. A Special Enrollment Period can occur if a person with other health coverage loses that coverage or if a person becomes a Dependent through marriage, birth, adoption or Placement for Adoption.

Special Enrollment Period Definitions

A. Special Enrollment for Loss of Other Coverage

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

1. You and/or your Dependent must otherwise be eligible for coverage under the terms of the Plan.

2. When the coverage was previously declined, you and/or your Dependent(s) must have been covered under another Group Health Plan or must have had other health insurance coverage.

3. When you declined enrollment for yourself or for your Dependent(s), you stated in writing that coverage under another Group Health Plan or other health insurance coverage was the reason for declining enrollment. This paragraph applies only if:

    a. The Plan required such a statement when you declined enrollment: and

    b. You are provided with notice of the requirements to provide the statement in this paragraph (and the consequences of your failure to provide the statement) at the time you declined enrollment.

4. When you declined enrollment for yourself or for your Dependent under the Plan:

    a. You and/or your Dependent had COBRA Continuation Coverage under another Plan and the COBRA Continuation Coverage under that other plan has since been exhausted; or

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

    For the purposes of the above provisions, "**exhaustion of COBRA Continuation Coverage**" means that the individual's COBRA Continuation Coverage has ceased for reasons other than failure to pay premiums on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). To exhaust COBRA Continuation Coverage, you or your dependent(s) must receive the maximum period of continuation coverage available without early termination.

"**Loss of eligibility of coverage**" includes a loss of coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, and any loss of eligibility after a period that is measured by reference to any of the foregoing. Loss of eligibility does not include a loss due to failure of the individual or the participant to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan).

5. Your application for special enrollment must be received by the Plan Administrator within **31** days following the loss of other coverage.

Effective Date of Coverage

You will need to check with the Plan Administration office to find out exactly when your coverage will become effective, but typically the coverage will be effective the first of the month following the date your other coverage ended.

If you do not apply for coverage within 31 days from the date of one of the special enrollment events described above, you will have to wait until the Plan's next Renewal Period to Enroll.

B. Special Enrollment for New Dependents

A Special Enrollment Period occurs if a person has a new Dependent by birth, marriage, adoption, or Placement for Adoption. To Enroll an adopted child, a copy of the court order or adoption papers must accompany the enrollment form. Special enrollment rules provide that:

1. You may enroll when you marry or have a new child (as a result of marriage, birth, adoption or Placement for Adoption).

2. Your spouse can be enrolled separately at the time of marriage or when a child is born, adopted, or Placed for Adoption.

3. Your spouse can be enrolled together with you when you marry or when a child is born, adopted or Placed for Adoption.

4. A child who becomes your Dependent as a result of marriage, birth, adoption or Placement for Adoption can be enrolled when the child becomes a Dependent.

5. Similarly, a child who becomes your Dependent as a result of marriage, birth, adoption or Placement for Adoption can be enrolled if you enroll at the same time.

6. Your application for special enrollment must be received by the Plan Administrator within **31** days following the date of the event.

Newborn Children: If you choose NOT to Enroll your newborn child, coverage for that child will be included under the mother's maternity benefits (provided the mother is enrolled under this Plan) for **48** hours following a vaginal delivery, or **96** hours following a cesarean section. **Benefits are not provided for an infant of a Dependent child**.

If you ARE going to enroll your newborn child, please make sure your application (including your child's name and date of birth) is received within **31** days of the child's date of birth.

Effective Date of Coverage

Coverage with respect to marriage is effective the first of the month following the date you were married.

Coverage with respect to birth, adoption or Placement for Adoption is effective on the date of birth, adoption or Placement for Adoption.

If you do not apply for coverage within **31** days from the date of one of the special enrollment events described above, you will have to wait until the Plan's next Renewal Period to Enroll.

C. Special Enrollment for Court-Ordered Dependent Coverage

The Plan will honor certain **Q**ualified **M**edical **C**hild **S**upport **O**rders (QMCSO) requiring coverage be provided for a Dependent child under the Employee's coverage. To be qualified, a court of competent jurisdiction must enter an order for child support requiring coverage under the Group Health Plan on behalf of your children. An order or notice issued through a state administrative process that has the force of law may also provide for such coverage and be a QMCSO.

The order must include specific information such as:

- Your name and address;
- The name and address of any child covered by the order;
- A reasonable description of the type of coverage to be provided to the child or the manner by which the coverage is to be determined;
- The period to which the order applies; and
- Each Group Health Plan to which the order applies.

To be a qualified order, the order cannot require the Plan to provide any type or form of Benefits or any option not otherwise provided by Plan, except as otherwise required by law. You will be responsible for paying all applicable premium contributions and any Co-Pay, Deductible, Co-Insurance or other cost sharing provisions which apply to you and your Dependent's coverage.

The Plan has to follow certain procedures with respect to a QMCSO. If such an order is issued concerning your child, you should contact the Plan Administrators Office.

Effective Date of Coverage

The Effective Date will be determined by the Plan Administrator in accordance with the provisions of the court order.

D. Special Enrollment Related to Medicaid and Child Health Insurance Program (CHIP) Coverage

The Children's Health Insurance Program Reauthorization Act (CHIPRA) created two additional special enrollment rights related to an individual's **(1)** loss of Medicaid or CHIP coverage, or **(2)** eligibility for a Group Health Plan premiums subsidy funded by Medicaid or CHIP. A **60-**day Special Enrollment Period occurs when Employees and Dependents who are eligible but not enrolled for coverage in the Plan experience either of the following qualifying events:

1. The Employee's or Dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility; or

2. The Employee or Dependent becomes eligible for Medicaid or Group Health Plan premium assistance subsidy under CHIP.

An Employee must request this special enrollment into the Plan within **60** days of the loss of Medicaid or CHIP coverage, and within **60** days of the Employee or Dependent becoming eligible for Group Health Plan premium assistance subsidy under Medicaid or CHIP. Coverage under special enrollment will be effective no later than the first day of the month after the Plan receives the special enrollment request.

Note: If an employee is enrolled in Exchange coverage instead of employer group coverage, and the Exchange coverage premium increases (whether due to a general premium increase or loss of a subsidy), that does not open up a Special Enrollment Period for an employee to switch to the employer group coverage. The employee will need to wait until the Health Plan's Annual Renewal Period to enroll in the employer group coverage.

Change in Status Disenrollment Period

A Change in Status is an occurrence that dramatically changes the health insurance needs for you or your Eligible Dependents. If you have a Change in Status occur, it allows you to cancel coverage (disenroll) to accommodate significant changes without waiting until the Plan's next Renewal Period, but only if the change is necessary or appropriate as a result of the event giving rise to the Change in Status. The Change in Status Disenrollment Period only applies to Employee's who participate in their Employer's Section 125 Premium Only Plan.

You must report the Change in Status either to your Employer or the Plan Administration Office within **31** days of the event, unless stated otherwise in this Benefit Book. If you do not, then you will have to wait until the Plan's next Renewal Period to cancel coverage.

Following are some examples of a Change of Status that would give you an opportunity to terminate coverage for yourself and/or your Dependents:

- **Change in legal marital status**, including marriage, divorce, death of a spouse, legal separation or annulment;
- **Change in the number of Dependent children,** including birth, adoption, placement for adoption, or death of a Dependent;
- **Change in employment status of Employee**, including a change in the individual's eligibility for an employee benefit plan or reduction in hours;

- **Change in spouse or child's employment status** (e.g. Spouse changes jobs and is eligible for coverage with new employer, or Spouses' employer offers coverage for the first time);
- **Dependent ceases to satisfy the eligibility requirements** (e.g. Dependent child turns age 26);
- **Change in coverage of spouse or Dependent child(ren) under another employer plan;**
- **Medicare or Medicaid Entitlement;**
- **Significant increase in the cost of an Employee benefit package during a Plan Year, or, the coverage under a benefit package is significantly curtailed;**
- **Change in residence of the Employee, spouse or Dependent child(ren).**
- **Enrollment in the Healthcare Exchange during the Exchange's open enrollment period.**

Provided you have reported the eligible Change in Status event within **31** days of the event **AND** you have provided documentation (proof) of the event (see next paragraph for documentation requirements), your coverage termination may be effective either the first day of the month following the Change in Status event or the first day of the current month. The date of change will be based on your specific situation.

For additional information on election changes you can make under a Section 125 Premium Only Plan, please see your Benefit Coordinator or the Section 125 Summary Plan Description that was provided to you at the time of election under the Premium Only Plan, as it supersedes this Benefit Book.

Documentation Requirements for Special Enrollment Period and Change in Status Events

If you meet the criteria for a Special Enrollment Period or a Change in Status and you request to make changes to your coverage due to that event, you must supply the Plan with the appropriate documentation as proof of that event before such changes can be made.

Examples of documentation required:

- Marital status change – copy of marriage certificate, last page of annulment, separation or divorce decree, or death certificate
- Birth of a child – copy of birth certificate
- Adoption/Legal guardianship – copy of document showing adoption/legal guardianship
- Loss of other coverage – copy of Certificate of Coverage showing date coverage ended
- Acquiring new coverage – Proof of new coverage showing effective date
- Court-ordered child support – copy of the court order with date and court signature
- All Others – call the Plan Administration office at **1-800-468-5744** to find out the requirements for your special event.

If the documentation (proof) is not provided to the plan within **31 days** of the requested coverage change date, then the coverage change will not be allowed and the Employee will have to wait until the next Renewal Period to make that change.

Survivor's Rights

Surviving spouses and Dependent children have **60** days following the date of the Employee's death to notify the Plan if they wish to continue their current coverage (with the exception of Life Insurance, as it is excluded from continuation). They do not have to continue medical and prescription drug coverage in order to continue dental and/or vision. Coverage will be retroactive to the first day of the month following the Employee's death.

The surviving spouse is eligible to continue coverage unless the spouse remarries or is eligible to be covered by other group insurance, military or Indian health benefits, whichever comes first, provided premiums are paid.

Surviving Dependent children are eligible to continue coverage until age **26,** unless they are eligible to be covered by other group insurance, military or Indian health benefits, provided premiums are paid. Over-aged Disabled Dependent children will be eligible to continue surviving coverage as long as they continue to meet the Plan's definition of a Disabled Dependent child.

At age **65**, the surviving spouse will not be allowed to continue the Plan's medical or prescription coverage (they can still continue other coverage's they might already have such as dental or vision). Instead, the Plan Administrator will guide the surviving spouse through the process of electing a group sponsored Medicare Advantage Open Access PPO plan through BlueCross and BlueShield of Oklahoma.

Premium rates are subject to change at any time as set by the Inter-Local Governmental Agreement.

Retiree Options

Who's eligible to continue coverage with the Plan after retirement?

Members of the Health Plan will be considered eligible for retiree coverage for **30** days following their employment end date, if during the period immediately prior to their retirement, either the sum of the member's age plus their years of service (calculated from their employment start date) with the Participating Government Agency equals at least the number **80** on the date they retire (their employment end date); or, the individual is **vested** with one of the following:

- Oklahoma Teachers Retirement System (OTRS)
- Oklahoma Public Employees Retirement System (OPERS)
- Oklahoma Law Enforcement Retirement System (OLERS)
- Oklahoma Municipal Retirement Fund (OkMRF)
- Other such Oklahoma Retirement Systems

If you are eligible for retiree coverage and you had Dependent(s) covered on the Plan at the time of retirement, then you can also continue their coverage when you retire. Coverage can continue as long as you remain eligible and the Employer from which you retired or vested continues to participate in the Plan. If the Employer terminates its' participation in the Plan, then you and your Dependents must follow the Employer to their new insurance carrier.

As an eligible retiree, you may not elect more coverage than what you had through the Plan at the time of your retirement. For example, if you did not have dental coverage at the time of your retirement, then you are not eligible to add it as a retiree. On that same note, if you are eligible for a particular coverage (like vision, for example) and you decide not to continue that coverage when you first retire, then you cannot add it at a later time. You can, however, cancel or decrease coverage at any time, but it can never be reinstated or increased.

Election to continue retiree coverage must be made within **30** days of termination of full-time employment.

Premiums rates are subject to change at any time as set forth in the Inter-local Governmental Agreement.

What coverage is available to Retirees?

You may not elect more coverage than you had through the Plan as an active Employee immediately prior to retirement. If you do not elect coverage for which you are eligible during the initial retiree enrollment, you are not permitted to add coverage at a later date. However, selected retiree coverage can be decreased or cancelled at any time. Available retiree coverage is dependent on the retiree's/spouse's age as described below.

Following are your options for retiree coverage under the Plan:

- **Retiree Medical & Prescription Coverage**
    - **Under Age 65 (pre-Medicare) Retirees and Dependents**
      You, or your spouse (under age 65) and/or Dependent children, may continue the same medical and prescription drug coverage that was in place when you were an active Employee (until age 65). You will continue to use the same ID cards for medical and prescription unless you change to a different coverage option (retirees may select from any Health Plan coverage option that is equal to lesser than the coverage option they had in place at the time of retirement). Medical and prescription drug coverage are bundled together, so you must elect one in order to get the other.

    - **65 Years of Age or Older (Medicare age) -** If you, or your spouse, are age **65** or older at the time you retire or turn 65 while enrolled under retiree coverage, you are not eligible to keep the same medical and prescription drug coverage. Instead, the Plan offers two types of Medicare products. 1.) A Group Medicare Advantage Open Access PPO plan through BlueCross and BlueShield of Oklahoma that bundles all of the benefits of Original Medicare Parts A & B plus Part D Prescription Drug coverage, plus additional health and wellness benefits not covered under original Medicare. You must be eligible for and enrolled in Medicare Parts A & B and continue to pay your Part B premiums in order to be eligible for a Medicare Advantage plan. Or 2.) An individual Medicare Supplement plan through BlueCross and BlueShield of Oklahoma, and an individual Medicare Part D Prescription Drug plan.

If for some reason you are age 65 or older and not eligible for Medicare, then you are not eligible to enroll or remain enrolled in the Plan's medical and prescription drug coverage.

Dependents who are enrolled under your plan who are under age 65 can continue the under 65 coverage they already have. Only the age 65 or older individual will switch to the Group Medicare Advantage Open Access PPO plan.

- **Under Age 65 and Eligible for Medicare Due to Disability**
  If you become entitled to Social Security Disability and become eligible for Medicare under the age of 65, then you are also eligible for either of the Medicare products mentioned above.

- **Retiree Dental Coverage**
  - **Regardless of age** - You and your spouse/and or Dependent children may continue the same dental coverage that was in place when you were an active Employee. You will continue to use the same ID card. Dental is not bundled with medical, so you have the option to continue dental without continuing medical.

- **Retiree Vision Coverage**
  - **Regardless of age** - You and your spouse and/or Dependent children may continue the same vision coverage that was in place when you were an active Employee. There are **no ID cards** for the vision coverage.

- **Retiree Life Insurance**
  - **Regardless of age** - You can choose from 4 different Group Term-Life Insurance amounts: **$5,000, $10,000, $15,000 or $20,000**. The Life Insurance is guaranteed issue (which means that you do not have to complete a Statement of Health and be subject to underwriting approval). In the event of your death, your chosen beneficiary(s) will receive the full amount of coverage elected. However, you must be Actively at Work on the day before you retire to be eligible to elect retiree life coverage.

    With the Retiree Group Term-Life policy, you have the option of including coverage for your spouse at **50%** of the amount that you choose for an additional premium, or, you can exclude the spouse portion of coverage. The spouse does not have to participate in the Plan's health coverage in order to be eligible for this coverage. If you select the spouse coverage, then in the event of your spouse's death, you will receive a life benefit equal to **50%** of your selected life insurance coverage amount, up to a maximum of $10,000.

    See the "**Life Insurance Benefits**" section for options on converting the life insurance you had as an active employee to an individual whole life policy directly with the Plan's Life Insurance vendor.

When will my retiree coverage begin?

Retiree coverage will be effective on the first day of the month following the date of retirement and loss of Employee coverage.

Will my retirement program help pay any of my premiums?

If you are an eligible retiree and you participate in an **O**klahoma public entity retirement system program (such as OPERS or OTRS) and you are vested when you retire, you might be eligible for a contribution from your retirement program to help offset the cost of your Plan medical premiums or Medicare Plan premiums as long as you continue your coverage through your Employer group plan (the contribution doesn't apply to prescription, dental, vision or life premiums). You can check with your retirement program to see if you are eligible for this contribution.

The Plan is approved to receive contributions towards your medical premiums from OPERS and OTRS retirement systems. If you qualify for this contribution, the Plan will bill you for your normal premiums less the contribution amount.

Example: Your retiree medical/prescription, dental & vision premiums for the month total **$798.62**. Your OPERS contribution is **$105**, therefore the Plan would bill you for the net amount of **$693.62**.

When are my retiree premiums due and how do I pay for them?

Your retiree premiums are due by the **1st** day of each month. The Plan does not send out invoices, so you must remember to send in your monthly payment by the due date. If you so choose, the Plan also has available a direct debit option in which the Plan will automatically deduct your premiums from your preferred bank account each month on a set date. For more information, please contact the Plan Administrator.

If your payment is not received by the 1st day of each month, then your coverage under the Plan will be suspended. You will be given a grace period of **30** days to make the payment for that month (coverage period). If your payment is received before the end of the grace period, then your coverage will be reinstated retroactively to the first day of the coverage period. If your monthly payment is not received by the end of the **30** day grace period, then your coverage will be cancelled as of the first day of the coverage period for which payment was due.

Exception: If you are having the Plan automatically debit your premiums from your bank account, then this will occur either on the **5th** or the **15th** of each month and your payment will **not** be considered late.

When does retiree coverage end?

You may continue your retiree coverage through the Plan until one of the following events occurs. Upon occurrence, your coverage will automatically terminate on the earliest of any of the following dates:

- The date the Plan ceases to exist;
- The end of the month for which the last premium payment was received for your coverage;
- Upon your death (see "**Survivor's Rights"** section if applicable); or

- You may continue coverage through the Plan as long as the Employer from which you retired or vested continues to participate in the Plan. If the Employer terminates its participation in the Plan, you must follow the Employer to the new insurance carrier and will no longer be eligible to participate in the Plan.

Extension of Benefits

There is no Extension of Benefits provided under the Plan except to the extent provided under the COBRA Continuation Coverage (see “**COBRA Continuation Coverage”** section below).

Conversion

Do I have the right to convert my coverage to an individual policy?

The only product that can be converted to an individual policy is the group life and additional life coverage. Once your life coverage with the Plan ends, you will receive a notice in the mail with an offer to convert the policy you might have had as an active Employee to an individual policy directly with the Plans’ Life Insurance vendor. Your eligible Dependents that you might have had covered on the group life or additional life coverage are eligible for the conversion too.

COBRA Continuation Coverage

What is COBRA?

COBRA Continuation Coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a qualifying event.

The right to COBRA Continuation Coverage was created by a federal law, the **C**onsolidated **O**mnibus **B**udget **R**econciliation **A**ct of 1985 (COBRA). COBRA Continuation Coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their coverage under the Plan.

Who can elect COBRA Continuation Coverage?

After a qualifying event, COBRA Continuation Coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse and your Dependent child(ren) could become qualified beneficiaries if coverage under the Plan is lost because of a qualifying event. In order to be a qualified beneficiary, a person must generally be covered under the Plan on the day before the qualifying event that caused the loss of coverage. However, a child who is born to you or placed for adoption with you (the covered Employee), during the period of COBRA Continuation Coverage will be a qualified beneficiary and will have all the rights of a qualified beneficiary.

Each qualified beneficiary who elects COBRA Continuation Coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including renewal or special enrollment rights if applicable. Under the Plan, qualified beneficiaries who elect COBRA Continuation Coverage generally must pay for this coverage.

What are the qualifying events that make me and/or my family eligible for COBRA Continuation Coverage?

- If you are an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because one of the following qualifying events happens:
  - Your hours of employment are reduced; or
  - Your employment ends for any reason other than your gross misconduct.
- If you are the spouse of an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:
  - Your spouse dies;
  - Your spouse's hours of employment are reduced;
  - Your spouse's employment ends for any reason other than his or her gross misconduct;
  - Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
  - You become divorced or legally separated from your spouse.
- Your Dependent child(ren) will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happen:
  - The parent/Employee dies;
  - The parent/Employee's hours of employment are reduced;
  - The parent/Employee's employment ends for any reason other than his or her gross misconduct;
  - The parent/Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
  - The parents become divorced or legally separated; or
  - The child stops being eligible for coverage under the Plan as a "Dependent child."
- Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your Employer, and that bankruptcy results in the loss of coverage of any retired Employee covered under the Plan, the retired Employee will become a qualified beneficiary with respect to the bankruptcy. The retired Employee's spouse, surviving spouse, and Dependent child(ren) will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

Who notifies the Plan Administrator when a qualifying event has occurred?

The Plan will offer COBRA Continuation Coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Employee, commencement of a proceeding in bankruptcy with respect to the Employer, or the Employee's becoming entitled to

Medicare benefits (under Part A, Part B, or both), the Employer must notify the Plan Administrator of the qualifying event within **30** days.

For the other qualifying events (divorce or legal separation of the Employee and spouse or a dependent child's losing eligibility for coverage as a Dependent child), you, or the qualified beneficiary, must notify the Plan Administrator in writing within **60** days after the later of: **(i)** the date the qualifying event occurs; or **(ii)** the date the qualified beneficiary would lose coverage due to the qualifying event, and provide any required information or documentation. If this notice deadline is not met, the notice will be rejected as untimely and the right to COBRA Continuation Coverage will be lost.

How long can COBRA Continuation Coverage last?

COBRA Continuation coverage can last up to **18** months if the loss of coverage is due to end of employment or reduction of the Employee's hours of employment.

If the loss of coverage is due to the Employee's death, divorce or legal separation, the Employee's becoming entitled to Medicare benefits or a Dependent child ceasing to be a Dependent under the terms of the Plan, coverage may be continued for up to a total of **36** months.

When the qualifying event is the end of employment or reduction of the Employee's hours of employment, and the Employee became entitled to Medicare benefits less than **18** months before the qualifying event, COBRA Continuation Coverage for qualified beneficiaries other than the Employee can last until **36** months after the date of Medicare entitlement.

How do I continue my coverage under COBRA?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA Continuation Coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary has a separate right to elect COBRA Continuation Coverage. For example, the Employee's spouse may elect COBRA Continuation Coverage even if the Employee does not. COBRA Continuation Coverage may be elected for only one, several, or for all Dependent child(ren) who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any Dependent child(ren). The Employee or the Employee's spouse can elect COBRA Continuation Coverage on behalf of all of the qualified beneficiaries. A guardian or other legal representative of a qualified beneficiary can elect COBRA Continuation Coverage on behalf of the qualified beneficiary.

To elect COBRA Continuation Coverage, you must complete the COBRA Election Form provided by the Plan Administrator and furnish it according to the directions on the form. The election of COBRA Continuation Coverage must be made no later than **60** days of the later of: (i) the date of the COBRA Election Form; or (ii) the date the qualified beneficiary would lose coverage due to the qualifying event. Even if you initially reject COBRA Continuation Coverage, you may change your mind as long as you complete the COBRA Election Form and submit it to the Plan Administrator before the due date.

Deciding whether or not you want to elect COBRA

In considering whether to elect COBRA Continuation Coverage, you should take into account that you have special enrollment rights under federal law. When your group health coverage ends, you have the right to request special enrollment in another Group Health Plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends. You will also have the same special enrollment right at the end of COBRA Continuation Coverage for the maximum time available to you.

How much does COBRA Continuation Coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of COBRA Continuation Coverage. The amount a qualified beneficiary may be required to pay may not exceed **102** percent (or, in the case of an extension of COBRA Continuation Coverage due to a disability, **150** percent) of the cost to the Plan (including both Employer and Employee premiums) for coverage of a similarly situated Plan participant or beneficiary who is not receiving COBRA Continuation Coverage.

Note: It is a Plan policy that premiums for COBRA Continuation Coverage cannot be paid by the Employer without prior written approval by the Board of Review.

When is the premium for my COBRA Continuation Coverage due and where do I send it?

- **First payment for COBRA Continuation Coverage**

  If you elect COBRA Continuation Coverage, you do not have to send any payment with the COBRA Election Form. However, you must make your first payment for COBRA Continuation Coverage no later than **45** days after the date of your election. (This is the date the COBRA Election Form is postmarked, if mailed.) If you do not make your first payment for COBRA Continuation Coverage in full no later than **45** days after the date of your election, you will lose all COBRA Continuation Coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct as provided on the COBRA Election Form. You may contact the Plan Administrator to confirm the correct amount of your first payment.

- **Where to send COBRA payments**

  Your first payment and all monthly payments thereafter for COBRA Continuation Coverage should be sent to the Plan Administrator's Office at the following address:

  OPEH&W
  3851 Tuxedo Blvd, Suite C
  Bartlesville, OK 74006

  Make your check or money order payable to: **OPEH&W**

  Note: Your COBRA Continuation Coverage will not be reinstated until your payment is received. At such time that your payment is received (if within the **45** day time limit mentioned above), then your COBRA Continuation coverage will be reinstated retroactive to the first day that you were eligible for COBRA.

- **Periodic Payments for COBRA Continuation Coverage**

  After you make your first payment for COBRA Continuation Coverage, you will be required to make monthly payments for each subsequent coverage period. Under the Plan, each of these monthly payments for COBRA Continuation Coverage is due on the first day of the month for that coverage period. If you make a monthly payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan **will not** send periodic notices of payments due for these coverage periods.

- **Grace periods for Periodic Payments**

  Although monthly payments are due on the first day of the month, you will be given a grace period of 30 days to make the payment for that month (coverage period). If your monthly payment is not received by the first of the month, your coverage under the Plan will be suspended as of the first day of the coverage period for which payment is due. When and if your payment is received before the end of the grace period, then your coverage will be reinstated retroactively to the first day of the coverage period. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

- **Failure to make Periodic Payments**

  If you fail to make a monthly payment before the end of the grace period for that coverage period, you will lose all rights to COBRA Continuation Coverage under the Plan.

Events that can extend your COBRA Continuation Coverage

If you elect COBRA Continuation Coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the Plan Administrator of a disability or a second qualifying event in order to extend the period of COBRA Continuation Coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of COBRA Continuation Coverage.

- **Disability**

  An **11**-month extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the **60th** day of COBRA Continuation Coverage and must last at least until the end of the **18**-month period of COBRA Continuation Coverage. You must notify the Plan Administrator of that in writing before the end of the first **18** months of COBRA Continuation Coverage and within **60** days after the later of: **(i)** the date of the SSA's determination of disability; **(ii)** the date of the qualifying event; or **(iii)** the date coverage would be lost due to the qualifying event, and provide any required information or documentation. If this notice deadline is not met, the notice will be rejected as untimely and the right to the **11**-month extension will be lost. Each qualified beneficiary who has elected COBRA Continuation Coverage will be entitled to the **11**-month disability extension if one of them qualifies.

- **Second Qualifying Event**

  An **18**-month extension of coverage will be available to Dependents who elect COBRA Continuation Coverage if a second qualifying event occurs during the first **18** months of COBRA Continuation Coverage. The maximum amount of COBRA Continuation Coverage available when a second qualifying event occurs is **36** months. Such second qualifying events may include the death of a covered Employee, divorce or separation from the covered Employee, the covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a Dependent child's ceasing to be eligible for coverage as a Dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify the Plan Administrator in writing within **60** days after the later of: **(i)** the date the second qualifying event occurs; or **(ii)** the date the qualified beneficiary would lose coverage and provide any required information or documentation. If this notice deadline is not met, the notice will be rejected as untimely and the right to the **18**-month extension will be lost.

When does COBRA Continuation Coverage end?

A Covered Person's COBRA Continuation Coverage, when applicable, will terminate at the end of the month coinciding with or next following the earliest to occur of the following dates:

- The date the coverage period ends following expiration of the **18**-month, **29**-month or **36**-month COBRA Coverage period, whichever is applicable;

- The first day of the month that begins more than **30** days after the date of the Social Security Administration's (SSA) final determination that the covered person is no longer disabled (when coverage has been extended from **18** months to **29** months due to disability);

- The date on which the Employer stops providing any Group Health Plan to any Employee;

- The first day of the coverage period for which any required premiums are not paid in full and on time;

- The date a qualified beneficiary becomes covered, after electing COBRA Continuation Coverage, under another Group Health; or

- The date on which the covered person becomes (after the date of COBRA election) entitled to benefits under Medicare.

After electing COBRA Continuation Coverage, if the Covered Person is determined by the Social Security Administration (SSA) to no longer be disabled, or the Covered Person obtains other Group Health Plan coverage or Medicare benefits, as described above, you must notify the Plan Administrator as soon as reasonably possible.

COBRA Continuation Coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA Continuation Coverage (such as fraud).

Coverage that has been terminated for any of these reasons described above cannot be reinstated.

What happens if I am on COBRA and my former Employer leaves the Plan and obtains group health coverage elsewhere?

If your Employer decides to leave the Plan and obtains it's Group Health Plan coverage elsewhere, any individuals on COBRA under the Plan at that time must follow their former Employer to its new Group Health Plan and continue COBRA with that new Group Health Plan.

Keep the Plan informed of address changes

In order to protect you and your family's rights, you should keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Do I have the right to convert my COBRA Continuation Coverage to an individual policy?

No, this is not available.

HIPAA Certificate of Creditable Coverage

In accordance with the provisions of the **H**ealth **I**nsurance **P**ortability and **A**ccountability **A**ct of 1996 (HIPAA), all individuals who lose coverage under an employer-provided Group Health Plan, or who would have lost coverage but for an election to take COBRA Continuation Coverage, must be provided with a HIPAA Certificate of Creditable Coverage. This certificate gives detailed information about what coverage you had with the Plan and how long you had it. This information may be used to demonstrate "Creditable Coverage" to your new health plan or issuer of an individual health policy.

The Plan will automatically mail the Certificates of Creditable Coverage to individuals losing coverage, via first-class mail to the covered individual's last-known address.

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Medical & Dental Coverage

Some of the topics you will find in this section include:

- **What Provider Network the Plan uses and how to find an In-Network Provider**
- **How your medical & dental coverage works (In-Network and Out-of-Network)**
- **What happens if you need to use your coverage outside of Oklahoma or the US**
- **ID Cards**
- **Medical Necessity Limitations**
- **Understanding your Explanation of Benefits (EOB)**
- **Preauthorization of Benefits (what happens if you don't preauthorize?)**
- **Allowable Charges – What are they?**
- **Making Healthy Cheaper – Free Benefits**
- **Cost sharing details for medical & dental**
- **Covered medical & dental services**
- **Exclusions & Limitations for medical, prescription and dental**

Important Information about your Medical & Dental Coverage

Medical

What Provider Network does the Plan use for Medical Benefits?

This Plan uses the **BlueChoice PPO** provider network through BlueCross and BlueShield of Oklahoma. BlueCross and BlueShield of Oklahoma is also the Claims Administrator for the Plan's medical Benefits. This section will explain their role in your health care coverage and also will explain important cost containment features in your health care program. Together, these features allow you to receive quality health care in cost-effective settings, while helping you experience lower out-of-pocket expenses. Also, as this Network includes Providers who participate with BlueCross and BlueShield plans throughout the country, you can enjoy the advantages of In-Network Providers regardless of where you live or travel.

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

About the BlueChoice Network

The BlueChoice network is referred to as **P**referred **P**rovider **O**rganization (PPO) and offers a wide selection of In-Network Providers. BlueCross and BlueShield of Oklahoma has negotiated special agreements with Hospitals, Outpatient facilities, Physicians and other health care professionals from many specialties for this PPO network. These participating health care Providers work with BlueCross and BlueShield of Oklahoma to help keep down the cost of health care. Although you are free to choose from any health care Provider for your health care services, you will receive the highest level of Benefits (and therefore lower out-of-pocket costs) if you utilize an In-Network Provider.

In-Network Providers are not employees, agents or other legal representatives of BlueCross and BlueShield of Oklahoma.

Throughout the rest of this Benefit Book, the term "In-Network Provider" will be used to refer to the BlueChoice PPO Network.

How does my In-Network coverage work?

Your In-Network coverage is designed to give Covered Persons some control over the cost of their own health care. Covered Persons continue to have complete freedom of choice in their Provider selection. However, the program offers considerable financial advantages to those who choose to use an In-Network Provider.

In contrast, when health care is received from a Physician who is not an In-Network Provider, your eligible claims will be subject to higher Co-Insurance and more Out-of-Pocket costs due to a separate Out-of-Network Deductible and Balance Billing.

How can I find an In-Network Provider?

A list of In-Network Providers is available on-line through the BlueCross and BlueShield of Oklahoma website at **www.bcbsok.com.** Although every effort is made to provide an accurate listing of In-Network Providers, additions and deletions will occur. Therefore, you should always check to be sure of your Provider's Network affiliation.

If you do not have internet access, you may also obtain In-Network Provider information, including a listing of providers, by contacting a BlueCross and BlueShield of Oklahoma customer service representative at **1-800-672-2567.** Or, you can ask the Provider directly if they are an In-Network Provider in your specific Provider Network.

How do I contact BlueCross and BlueShield of Oklahoma?

Call Customer Service at **1-800-672-2567**,

or, you can write to: **BlueCross and BlueShield of Oklahoma**

P.O. Box 3283

Tulsa, OK 74102-3283

IMPORTANT…

Keep in mind that all Covered Services (including ancillary services such as x-ray and laboratory services, anesthesia, etc.) must be performed by an In-Network Provider in order to receive the highest level of Benefits under the Plan. If your Physician prescribes other services, check to see if the provider he/she refers you to is an In-Network Provider whenever possible.

What if I need to use my medical coverage when I'm outside the state of Oklahoma, or outside of the United States?

As a BlueCross and BlueShield Covered Person, you enjoy the convenience of carrying your Identification Card – The BlueCard. The BlueCard program allows you to use a BlueCross and BlueShield Physician or Hospital outside the state of Oklahoma or even outside of the U.S. and to receive the advantages of benefits and savings.

- **Finding a Doctor or Hospital:**

  When you're outside of Oklahoma or outside of the U.S. and you need medical care, just call the BCBS Global Core Service Center at **1-800-810-BLUE (2583)** and they'll help you locate the nearest Doctor or Hospital, or you may refer to the BlueCross and BlueShield Provider Finder at www.bcbs.com. Click on Find a Doctor, then choose "In the United States" or "Outside the United States". If you need to call the Global Core Service Center via collect call, you can call **1-804-673-1177**.

  Remember, you are responsible for receiving Precertification from BlueCross and BlueShield 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 BlueCross and BlueShield Physician or Hospital across the USA. The Physicians and Hospitals can verify your membership, eligibility and coverage with BlueCross and BlueShield of Oklahoma. When you visit a BlueCard Physician or Hospital, you should have no claim form to file and no billing hassles.

- **Outside of the United States**

  By calling the BCBS Global Core Service Center at the number above and arranging for direct payment in advance, except for your normal out-of-pocket expenses (non-covered services, deductibles, co-pays and co-insurance), you should not need to pay upfront for inpatient care at designated hospitals. If direct payment has not been arranged, or your local BCBS plan is unable to verify your benefit coverage at the time of service, you may need to pay upfront and submit a claim for reimbursement. Complete a BCBS Global Core International Claim form and send it with the bill(s) and proof of payment to the BCBS Global Core Service Center (address on the form). The claim form is available from the Health Plan, or you can download it at www.bcbsglobalcore.com.

- **Remember to Always Carry the BlueCard**

  Make sure you always carry your Identification Card — The BlueCard. And be sure to use BlueCross and BlueShield 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 BlueCross and BlueShield of Oklahoma today.

Note: BlueCross and BlueShield of Oklahoma may post-pone application of your Co-Pay, Deductible and/or Co-Insurance amounts whenever necessary so that they may obtain a Provider discount for you on Covered Services you receive outside of Oklahoma.

Dental

What Provider Network does the Plan use for dental Benefits?

The plan utilizes the BlueCare Dental Network of America, also known as DNoA, through BlueCross and BlueShield of Oklahoma. Covered Persons have access to thousands of Participating Dentists nationwide. Here's how using a Participating Dentist can benefit you:

- A Participating Dentist will file your claims for you.

- Payment for Covered Services you receive will be sent directly to the Participating Dentist.

- For Covered Services, you only have to pay the applicable Deductible and/or Co-Insurance amount. **If your Participating Dentist charges more than the Plan's allowance for Covered Services, you aren't responsible for the difference.**

Covered Persons living or traveling outside the state of Oklahoma may show their Identification Card to receive full, In−Network Benefits from any Participating Dentist nationwide.

To locate a Participating Dentist, please call a Customer Service Representatives at **1−888−381−9727**. You may also look up in−state (Oklahoma) and out−of−state Dentists on the “Provider Directory” section of the BlueCross and BlueShield of Oklahoma Web site at **www.bcbsok.com**.

How does my dental coverage work?

This dental program is designed to give Covered Persons some control over the cost of their own dental care. Covered Persons continue to have complete freedom of choice as to the Dentist they wish to use. However, the program offers considerable financial advantages to Covered Persons whenever they use a Participating Dentist.

If you need services which cannot be performed by your Participating Dentist, ask your Dentist to refer you to a specialist within the Participating Dentist Network to assure you receive the highest level of Benefits under this program.

Medical & Dental

Online access to BlueCross and BlueShield of Oklahoma

As a member of the BlueCross and BlueShield of Oklahoma Network, you can get immediate online access to health and information through the Blue Access for Members website, or through the BlueCross and BlueShield mobile app. Here are some other great tools and resources you can find on the secure member portal or mobile app:

- Check the status of a claim and your claims history
- Confirm who in your family is covered under your Plan
- Locate a Physician or Hospital in the Network
- View and print an **E**xplanation **o**f **B**enefits (EOB) for a claim
- Select an option to stop receiving EOB’s in the mail
- Sign up to receive claim status email alerts
- Request a new or replacement member ID Card or print a temporary member ID Card; for the mobile app, you can access a temporary digital member ID card
- Apply for a Member Reward

For the website, just follow these **3** steps:

1. Go to **www.bcbsok.com.**
2. Find **Blue Access for Members** on the top right side of the screen. Click the “Register Now” link.

3. Use the information on your BlueCross and BlueShield of Oklahoma ID Card to complete the registration process.

The Mobile App is available for iPhone and Android users. To download the app, text **BCBSOKAPP** to **33633** or search BCBSOK in the Apple App Store or Google Play. Message and data rates may apply.

Identification (ID) Cards for Medical & Dental

You will receive two separate Identification (ID) Cards, one for medical and one for dental, to show the Hospital, Physician, Dentist or other Providers when you need to use your coverage. Your ID Card shows the Plan in which you are enrolled, the PPO Network in which your group participates 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 upon request.

Carry your ID card at all times. If you lose your ID card, you can still use your coverage.

Legal requirements govern the use of your ID card. You cannot let anyone who is not enrolled in your coverage use your ID card(s). Nor can you let anyone not enrolled in your coverage use your Benefits or receive payment for them.

- **Additional ID Cards**

  Whether you just need additional cards for family members or your card has been lost, you can call the Plan Administration office at **1-800-468-5744** to request additional ID cards. You can also go to **www.bcbsok.com** and log-in to your BlueAccess for Members account to order an ID Card(s) directly and/or download a temporary ID card. You can also access a digital member ID card on the BCBS Mobile App.

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.

The Plan provides Benefits for Covered Services that are Medically Necessary. “Medically Necessary” is 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.

Explanation of Benefits (EOB)

After BlueCross and BlueShield of Oklahoma processes each of your claims, they will generate a document called an **E**xplanation **of** **B**enefits (hereafter referred to as an **EOB)**. The EOB displays the charges submitted by your Provider and shows how the claim was processed. The EOB is not a bill. Your provider may bill your separately

The EOB has three major sections:

- **Subscriber Information and Claim Summary:** shows group name and number, member ID #, and a claim summary that shows you what the Plan paid and the amount you may owe.
- **Claim Detail:** shows patient and provider information, claim number and when it was processed.
- **How the Claim was Process/Adjusted**: service dates and descriptions, the amount billed, the discounts or other reductions subtracted from the amount billed, the total amount covered, amount the health plan pays and the amount you may owe the provider (your responsibility).
    - Your Responsibility – deductible and copay amounts, your share of coinsurance, amounts not covered, if any, and amount you may owe the provider. You may have paid some of this amount, like your office visit copay, at the time you received the service.

The EOB may include additional information, such as;

- **Amounts Not Covered:** will show what benefit limitations or exclusions apply.
- **Out-of-Pocket Expenses:** will show an amount when a claim applies toward your Deductible or counts toward your Out-of-Pocket expenses.
- **Fraud Hotline:** provides a toll-free number you can call if you think you are being charged for services you did not receive or if you suspect any fraudulent activity.
- **An Explanation** of your rights to appeal if the Health Plan doesn't cover a health care claim.

Your EOB's are always available online at **www.bcbsok.com**. Sign up for Blue Access for Members (BAM) for convenient access to your claim information and history. You can choose to opt out of receiving EOB's by mail to save time and resources. Go to BAM, click on User Profile and change your User Preferences. **See the next page for details on how to read and understand your EOB.**

BlueCross BlueShield of Oklahoma
PO Box 7344
Chicago, IL 60680-7344

EXPLANATION OF BENEFITS

Log into **Blue Access for Members**^{SM} at **bcbsok.com**
- View plan and claim details
- Contact us through our secure Message Center
- Sign up for digital health plan info
- Search for health care providers

Text* **GOBCBSOK** to **33633** to download the mobile app.

Have questions about this EOB? Customer Advocates are here to help! **800-409-9462**

John Smith
1234 Cedar Road
APT #2
Any Town, OK 76065

Sample

SUBSCRIBER INFORMATION

GROUP NAME
Member ID#: XXXXXXXXX**777V** Group #: **000012345**

Dear John Smith,

An Explanation of Benefits (EOB) is a statement showing how claims were processed. **This is not a bill.** Your provider(s) may bill you directly for any amount you may owe. **KEEP FOR YOUR RECORDS.**

HELPFUL INFORMATION

Access Your Health Documents Online

Get convenient and secure online access to your Blue Cross and Blue Shield of Oklahoma (BCBSOK) health plan information. Log in or register for Blue Access for Members at bcbsok.com/member. Select Settings, then Preferences in the top navigation bar to choose email and text alert preferences.

Health Care Fraud Hotline: 800-543-0867

Health care fraud affects health care costs for all of us. If you suspect any person or company of defrauding or attempting to defraud Blue Cross and Blue Shield of Oklahoma, please call our toll-free hotline. All calls are confidential and may be made anonymously. For more information about health care fraud, please go to **bcbsok.com.**

GLOSSARY OF TERMS - We have described some of the terms used here to help you understand them, but you should make sure to read your benefit plan materials if you have questions.

Amount Billed: The amount your provider billed for the service(s) rendered.

Amount Covered (Allowed): Discounts, reductions, and amount covered (allowed) reflect the terms of your plan, and in the case of an in-network provider, the savings we have negotiated with your provider. Your deductible, coinsurance and copay are based on the allowed amount and the terms of your plan. Your share of coinsurance is a percentage of the allowed amount after the deductible is met.

Coinsurance: The percentage of the allowed amount you pay as your share of the bill. If your plan pays 80% after coinsurance of the allowed amount, then 20% would be your coinsurance.

Copay Amount (Also known as Copayment): The set fee you pay each time you receive a certain service. Some plans do not have copayments.

Deductible: The amount, if any, you must pay before we start paying contract benefits. You do not send this amount to us. We subtract this amount from covered expenses on claims you and health care professionals send us. Some services can be covered before the deductible is met.

Non-Participating Provider: An out-of-network provider who does not accept rates for services we set to keep your costs down.

Out-of-Pocket Limit: Once you pay this amount in deductibles, copayments and coinsurance for covered services, we pay 100% of the allowed amount for covered services for the rest of the benefit period.

Participating Provider: An in-network or out-of-network provider who accepts agreed-upon rates for services.

Your Total Costs: This is the sum of your copay, deductible and coinsurance. It also includes any amounts not covered by your health plan. Amounts that a non-participating provider may bill you are not part of this.

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*Message and data rates may apply. Terms & Conditions and Privacy Policy **bcbsok.com/text-messaging**
Blue Cross and Blue Shield of Oklahoma provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

BlueCross BlueShield of Oklahoma

SUBSCRIBER INFORMATION

GROUP NAME
Member ID#: XXXXXXXXX**777V** Group #: **000012345**
Customer Advocates are here to help! **<Customer Service Phone>**

Amount Billed	$7,850.00
Discounts and Reductions	- $3,930.00
Health Plan Responsibility	- $2,219.00
Paid from your HSA Account	- $0.00
You may owe your health care provider for these services	**$1,701.00**

CLAIM DETAIL (1 OF X)

Sample

PATIENT: John Smith
PROVIDER: Ralph Johnston M.D.
CLAIM # XXXXXXXXXXXXX **DATE PROCESSED:** 06/20/2019

We reviewed the claim for this patient based on the additional information received regarding other group health care coverage involvement. Blue Cross and Blue Shield has negotiated discounts with this provider. The following shows how this claim was adjusted.

			YOUR BENEFITS APPLIED			YOUR RESPONSIBILITY				
Service Description	Service Dates	Amount Billed	Discounts and Reductions	Amount Covered (Allowed)	Health Plan Responsibility	Deductible Amount	Copay Amount	Coinsurance	Amount Not Covered	**Your Total Costs**
Surgical Charges	04/04/2019	4,000.00	(1) 1,800.00	2,200.00	960.00	1,000.00		240.00		1,240.00
Recovery Room	04/04/2019	900.00	(1) 410.00	490.00	392.00			98.00		98.00
Med/Surg Supplies	04/04/2019	300.00	(1) 140.00	160.00	128.00			32.00		32.00
Med/Surg Supplies	04/04/2019	100.00							(2) 100.00	100.00
Laboratory Services	04/04/2019	1,200.00	(1) 820.00	380.00	304.00			76.00		76.00
Laboratory Services	04/04/2019	400.00	(1) 270.00	130.00	72.00		50.00	8.00		58.00
MRI Outpatient	04/04/2019	950.00	(1) 490.00	460.00	363.00		15.00	82.00		97.00
CLAIM TOTALS		**$7,850.00**	**$3,930.00**	**$3,820.00**	**$2,219.00**	**$1,000.00**	**$65.00**	**$536.00**	**$100.00**	**$1,701.00**

Total covered benefits approved for this claim: $2,219.00 to Ralph Johnston M.D. on 06-20-19.

Notes about amounts under "YOUR BENEFITS APPLIED" and "YOUR RESPONSIBILITY"

(1) The amount billed is greater than the amount allowed for this service. Based on our agreement with this provider, you will not be billed the difference.

(2) Your Health Care Plan does not provide benefits for surgical assistant services when billed by the same physician who performed the surgery or administered the anesthesia. No payment can be made.

Your health care plan has a calendar year maximum for x-rays and laboratory services performed in the outpatient department of a hospital, a clinic or a doctor's office. When this maximum has been reached, the balance is eligible under your major medical benefits, subject to a yearly deductible and a coinsurance share.

For benefit period 01-01-19 through 12-31-19 to date this patient has met $4,515.02 of her/his $7,350.00 Out-of-Pocket Expense Limit. **For your up-to-date Medical Spending summary, visit Blue Access for Members^{SM} at bcbsok.com, the BCBSOK Mobile App or call the phone number at the beginning of the claim information.**

Preauthorization

The Plan has designated certain Covered Services which require Preauthorization in order for you to receive the maximum Benefits possible under the Plan. If you are using an In-Network provider for your Covered Services, that provider will handle the Preauthorization for you. However, if you are using an Out-of-Network provider, then 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 guidelines below. Failure to Preauthorize services may result in a reduction in Benefits as described below under **"Failure to Preauthorize."**

- **Preauthorization Process for Inpatient Services**

  For an Inpatient facility stay, you must request Preauthorization from the Claims Administrator **before** your scheduled admission. The Claims Administrator will consult with your Physician or Hospital or other facility to determine if Inpatient level of care is required for your Illness or Injury. The Claims Administrator may decide that the treatment you need could be provided just as effectively in a less expensive setting (such as the Outpatient department of the Hospital, an Ambulatory Surgical Facility, or the Physician's office). If the Claims Administrator determines that your treatment does not require Inpatient care, you and your Provider will be notified of that decision.

  If you proceed with an Inpatient stay without the Claims Administrator's approval, or if you do not ask the Claims Administrator for Preauthorization, your Benefits under the Plan will be reduced as described below under "Failure to Preauthorize," provided the Claims Administrator determines that Benefits are payable upon receipt of a claim. This reduction applies in addition to any Benefit reduction associated with your use of an Out−of−Network Provider.

  For Preauthorization requests related to Urgent Care or Emergency Care, the Covered Person should refer to the Preauthorization procedures outlined below in this **"Preauthorization"** section.

- **Preauthorization Requests Involving Non−Urgent Care**

  Except in the case of a Preauthorization Request Involving Urgent Care/Expedited Clinical Claims (see below), the Claims Administrator will provide a written response to your Preauthorization request no later than **15** days following the date they receive your request. This period may be extended one time for up to **15** additional days, if the Claims Administrator determines that additional time is necessary due to matters beyond their control.

  If the Claims Administrator determines that additional time is necessary, they 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 they expect to make the determination.

  If an extension of time is necessary due to the Claims Administrator's need for additional information, they will notify you of the specific information needed, and you will have 45 days from receipt of the notice to provide the additional information. The Claims Administrator will provide a written response to your request for Preauthorization within **15** days following receipt of the additional information. The procedure for appealing an adverse Preauthorization determination is set forth in the section of this Benefit Book entitled "**Complaint/Appeal Procedures for Medical & Dental**."

- **Preauthorization Requests Involving Urgent Care/Expedited Clinical Claims**

  A “Preauthorization Request Involving Urgent Care/Expedited Clinical Claims” 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 Covered Person or the ability of the Covered Person to regain maximum function; or

  - In the opinion of a Physician with knowledge of the Covered Person’s medical condition, would subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Preauthorization request.

  In case of a “Preauthorization Request Involving Urgent Care/Expedited Clinical Claims,” the Claims Administrator will respond to you no later than **24** hours after receipt of the request, unless you fail to provide sufficient information, in which case, you will be notified of the missing information and will have no less than **48** hours to provide the information. A Benefit determination will be made within **72** hours after the missing information is received.

  NOTE: The Claims Administrator’s response to your Preauthorization Request Involving Urgent Care/Expedited Clinical Claims, 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 Requests Involving Emergency Care**

  If you are admitted to the Hospital for Emergency Care and there is not time to obtain Preauthorization, you will not be subject to the Preauthorization “penalty” (if any) outlined below if you or your Provider notifies the Claims Administrator within **2** working days following your emergency admission.

- **Preauthorization Process for Psychiatric Care Services**

  All **Inpatient and Outpatient** services related to treatment of Mental Illness, drug addiction, substance abuse, or alcoholism must be Preauthorized by the Claims Administrator. You or your Physician must call the Preauthorization number shown on the Covered Person’s Identification Card before receiving treatment. The Claims Administrator will assist in coordinating your care so that the treatment is received in the most appropriate setting for your condition and that you receive the highest level of Benefits under the Plan. If you do 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.

  Note: Preauthorization is required for all behavioral health services after **10** visits.

- **Failure to Preauthorize for Inpatient Hospital or Inpatient Psychiatric Care**

  If you do not call for Preauthorization for Inpatient Hospital or Inpatient Psychiatric Care services or treatment when using an Out-of-Network Provider, the admission will be subject to a **$1,000 Inpatient Hospital Preauthorization Penalty (Deductible)**. If it is determined that the services were not Medically Necessary or were Experimental/Investigational, it may be the Covered Person’s responsibility to pay the full cost of the services received.

If the Covered Person fails to obtain Preauthorization for Outpatient services or treatment for Mental Illness, drug abuse, substance abuse, alcoholism, or autism/autism spectrum disorders:

- the Claims Administrator will review the Medical Necessity of the treatment or service prior to the final Benefit determination.

- If the Claims Administrator determines the treatment or service is not Medically Necessary or is Experimental/Investigational, Benefits will be reduced or denied.

Please keep in mind that any treatment you receive which is not a Covered Service under the Plan, or which is not Medically Necessary, will be excluded. This applies even if Preauthorization approval is requested or received.

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

- **Additional services subject to Preauthorization**

  In addition to Inpatient Hospital and Psychiatric Care services, the following are also subject to Preauthorization. If you fail to request Preauthorization approval, or to abide by the Claims Administrator's determination regarding these services, your Benefits will be reduced or denied, as set forth in the covered **"Covered Medical Services"** section of this Benefit Book.

  - Human Organ, Tissue and Bone Marrow Transplant Services
  - Home Health Care
  - Private Duty Nursing Services
  - Skilled Nursing Facility Services
  - Hospice Care Services
  - Rehabilitation Care

Concurrent Review

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

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

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

Emergency Care Services

In the case of an emergency, when you get immediate medical assistance from a Hospital, Physician or other Provider that best meets the needs of your emergency, those Covered Services will receive the maximum allowable benefits based upon the Allowable Charge for those services. If you use an Out−of−Network Provider for your Emergency Care, you will not be subject to the higher Co-Insurance amounts normally associated with your use of an Out−of−Network Provider. See Emergency Care Services under "**Covered Medical Services**" for more detailed information.

It should be noted here that simply because care or treatment is received in an emergency department, it does not automatically qualify as Emergency Care. Emergency Care is defined as treatment for an Injury, Illness or condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a reasonable and prudent layperson could expect the absence of medical attention to result in:

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

When should I go to the Emergency Room? It's important to know where to go when you need medical care. Sometimes it's clear and at other times, it's not so clear. While the answer is not always simple, knowing your options and deciding where to go can mean the difference in costs and time. Use the charts below to help you decide where to go based on your health care need.

When the ER **Should be Used**

You should go to the ER for life-threatening symptoms, such as:

- Heart problems
- Breathing problems
- Heavy bleeding
- Broken bones
- Severe pain

When the ER **Shouldn't be Used**

You have choices other than the ER for health concerns like:

- Cold, sore throat
- Ear or sinus pain
- Rashes
- Cuts that don't need stitches
- Constipation

Choices **other than the ER**

Where to go when it's not an emergency:

- Your Doctor
- 24/7 Nurseline – 800-581-0393
- MDLive – virtual visit
- Retail clinics (ie: Urgent Care)

Allowable Charges

To take full advantage of the negotiated pricing arrangements in effect between the Claims Administrator and their Network Providers, it is imperative that you use the BlueChoice PPO Provider Network in Oklahoma and BlueCard Providers whenever you are out of state. Using these Providers offers you the following advantages:

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

REMEMBER…

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

- The Claims Administrator will calculate your Benefits based on this "Allowable Charge". They will deduct any charges for services which aren't eligible under your coverage, then subtract your Co-Pay, Deductible and/or Co-Insurance amounts which may be applicable to your Covered Services. They will then determine your Benefits under the Plan, and direct any payment to your In-Network Provider.

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

- The Allowable Charge for Non−Contracting (Out-of-Network) Providers for Covered Services will be the lesser of:
    - The Provider's billed charges; or
    - The Claims Administrator's Non−Contracting Allowable Charge.

The Non−Contracting Allowable Charge is developed from base Medicare reimbursements, excluding any Medicare adjustments using information on the claim, and adjusted by a predetermined factor established by the Claims Administrator. 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 In-Network Providers adjusted by a predetermined factor established by the Claims Administrator and updated on a periodic basis. Such factor shall not be less than **100%** of the average contract rate and will be updated not less than every two years.

The Claims Administrator will utilize the same claim processing rules and/or edits that it utilizes in processing Participating Provider claims for processing claims submitted by Non−Contracting Providers which may also alter the Allowable Charge for a particular service. In the event the Claims Administrator does not have any claim edits or rules, the Claims Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the claims. The Allowable Charge will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific claim, including but not limited to, disproportionate share and graduate medical education payments.

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

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

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

    - The median amount negotiated with Network or contracting Providers for the Emergency Care Services furnished;

    - The amount for the Emergency Care Services calculated using the same method the Claims Administrator generally uses to determine payments for Out−of−Network Provider services, but substituting the In−Network or contracting cost−sharing provisions for the Out−of−Network or Non−Contracting Provider cost sharing provisions; or

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

  Each of these three amounts is calculated excluding any Network or contracting Provider Co-Pay or Co-Insurance imposed with respect to the Covered Person.

- When Covered Services are received outside the state of Oklahoma from a Provider who does not have a written agreement with BlueCross and BlueShield of Oklahoma or with the local BlueCross and BlueShield Plan, the "Allowable Charge" will be determined by the BlueCross and BlueShield 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 or Co-Insurance amounts that are applicable to your coverage (including the higher Co-Insurance amounts which apply to Out−of−Network Provider services).

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

Designating an Authorized Representative

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

Cost-Sharing Features of your Coverage

As a participant in the Plan, you have the responsibility for sharing in a portion of your health care costs. You are responsible for the applicable Deductible, Co-Insurance and Co-Pay provisions of your coverage, as well as any charges for which Benefits are not provided.

Contributions for Employee and/or Dependent Coverage

Employee and/or Dependent premium contributions may be required. For further information about whether contributions from you are required, contact your Employer's Benefit Coordinator.

Questions?

Medical

You will usually be able to answer your medical coverage questions by referring to this Benefit Book. If you need more help, please call the Plan Administration office at **1-800-468-5744**, or you can talk to a BlueCross BlueShield Customer Service Representative at **1-800-313-5162**.

Or you can write: **BlueCross and BlueShield of Oklahoma**
P.O. Box 3283
Tulsa, Oklahoma 74102−3283

When you call or write, be sure to give your identification number which is on your medical Identification Card. If the question involves a claim, be sure to give:

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

Dental

For questions regarding your dental coverage, please call the Plan Administration office at **1-800-468-5744**, or you can talk to a BlueCross BlueShield Customer Service Representative at **1-888−381−9727**.

Or, you can write: **BlueCross and BlueShield of Oklahoma**
c/o Dental Network of America, Inc.
P.O. Box 23100
Belleville, Illinois 62223−0100

Making Healthy Cheaper

The OPEH&W Health Plan knows that today's medical benefits must be more dynamic and make healthy cheaper. That's why it packages all its medical plans with the following impressive and growing list of innovative enhancements. For more detailed information on each of these benefits, visit **www.opehw1.com/makinghealthycheaper.html**.

FREE Human Organ, Tissue & Bone Marrow Transplants through a **Blue Distinction Center**

FREE Back & Spine Surgeries through a **Blue Distinction Center**

FREE Cardiac Surgeries through a **Blue Distinction Center**

FREE Hip & Knee Replacement Surgeries through a **Blue Distinction Center**

FREE Cellular Immunotherapy through a **Blue Distinction Center**

FREE Maternity Care through a **Blue Distinction Center**

FREE Cash Rewards from Member Rewards through **BlueCross BlueShield & Zelis**

FREE Primary & Pediatric Care Telehealth with **MDLIVE**

FREE Psychiatry & Counseling Care Telehealth with **MDLIVE**

FREE Durable Medical Equipment & Supplies with **ConnectDME**

FREE MRI, CT, PET Scans, X-Rays & Ultrasounds with **Green Imaging**

FREE Diabetes & Diabetes Prevention Program with **Omada**

FREE High Blood Pressure Program with **Omada**

FREE High Cholesterol Program with **Omada**

FREE Muscle & Joint Pain Programs with **Hinge Health**

FREE Pelvic Floor Pain Program with **Hinge Health**

FREE Tobacco & Vaping Addiction Program with **Pelago**

FREE Opioid Addiction Program with **Pelago**

FREE Alcohol Addiction Program with **Pelago**

FREE Mental Health Program with **SilverCloud** and **inMynd** and **LearnToLive**

FREE Women's & Family Support Programs with **Ovia Health**

FREE Health & Wellness Programs with **Well on Target**

FREE Weight-Loss Program with **Wondr Health** & **Omada**

FREE In-Home Sleep Studies with **ConnectDME**

FREE $500 towards Dependent Accident Claims

$5	OTC Antihistamine Medications
$25	Insulins
$5	Diabetic Oral Generic Medications
50%	Dependent Deductible Reimbursement

Cost-Sharing Summary for Medical Services

The chart below summarizes your share of the costs of your Covered Medical Services under the Plan, for both In-Network and Out-of-Network Providers. Please note that services must be Medically Necessary in order to be covered under the Plan.

What You Pay

Cost-Sharing Features **(Subject to the "Cost-Sharing Details for Medical Services" section which follows)**	**In-Network**	**Out-of-Network**
Individual Plan Year Deductible*	**$1,000***	**$2,000**
Family Plan Year Deductible* (can be met by 2 or more family members)	**$2,000***	**$4,000**
Physician's Office Visit or Urgent Care Co-Pay	**$25****	**Subject to Deductible & Co-Insurance**
Specialist's Office Visit Co-Pay	**$50**	**Subject to Deductible & Co-Insurance**
Emergency Room Co-Pay (Only Applies to non-accident visits)	**$50**	**$50**
Co-Insurance (% of Allowable Charges)	**20%** (up to a maximum of $4,000)	**30%** (up to a maximum of $8,000) **Plus Balance Billing**
Individual Maximum Out-of-Pocket Limit (Maximum per person per plan year)	**$5,000**	**$10,000**
Family Maximum Out-of-Pocket Limit (Maximum per family per plan year; can be met by 2 or more family members)	**$10,000**	**$20,000**

*See special Plan provisions for covered Dependent children under the Dependent Child Deductible Reimbursement Program and Accidental Injury Services for Dependent Children.

** See MDLIVE under section "**Making Healthy Cheaper**" to learn about free Telehealth visits.

Cost-Sharing Details for Medical Services

This section gives you a general idea of what your share of the costs will be for your medical claims. Cost-sharing typically consists of Co-pays, Deductibles and Co-Insurance. For additional information, all of the terms just mentioned are also defined in the Glossary at the back of this Benefit Book.

Plan Year (Benefit Period): **July 1** through **June 30**

Office Visit Co-Pays: **$25** for each visit to an In-Network Primary Care Physician or Urgent Care

$50 for each visit to an In-Network Specialist

Emergency Room Co-Pay: **$50** for each visit to a Hospital for a non-Accident. However, this Co-Pay is waived if the Covered Person is admitted to the Hospital through the emergency room visit. Any services received through this visit are subject to the Deductible and Co-Insurance provisions of your coverage.

The Office Visit Co-Pay applies to charges which are billed as part of your Physician's office or urgent care visit. The Co-Pay will only apply to the office visit billed. The amount you pay for your Office Visit Co-Pay's and Emergency Room Co-Pay's count towards your Individual Maximum Out-of-Pocket Limit.

EXCEPTIONS:

- The Office Visit Co-Pay does not apply to the following services. Instead, these services are subject to the Deductible and Co-Insurance provisions of your coverage:

    - Surgical Services
    - Therapy Services, including but not limited to: Speech Therapy, Physical Therapy, Occupational Therapy and Chemotherapy
    - Allergy testing and allergy injections
    - Magnetic Resonance Imaging (MRI), Computer Tomography (CT Scan) and Positron Emission Tomography (PET Scan)
    - Durable Medical Equipment
    - Covered Childhood immunizations (for dependent children under age 19)
    - Out-of-Network office visits

- The office visit Co-Pay does not apply to Preventive Care Services, as the office visit and related Preventive Care Services are covered by the Plan at 100%.

Plan Year Deductible(s):

Except as noted otherwise in this Benefit Book, you are required to pay your Plan Year Deductible before the Plan starts to pay for its' portion of your Covered Services. Amounts that you pay out-of-pocket for services that are **NOT COVERED** by the Plan do not count towards your Deductible.

In-Network Deductible:	**$1,000** per Plan Year per Covered Person, or **$2,000** maximum for a family of **2** or more per Plan Year. No one person can meet more than **$1,000** of the family Deductible. This Deductible applies to Covered Services received from an In-Network Provider or BlueCard Provider. Any amounts a Covered Person pays towards their In-Network Deductible **do not** count towards satisfying their Out-of-Network Deductible.
Out-of-Network Deductible:	**$2,000** per Plan Year per Covered Person, or **$4,000** maximum for a family of **2** or more per Plan Year. No one person can meet more than **$2,000** of the family Deductible. This Deductible applies to Covered Services received from an Out-of-Network Provider. Any amounts a Covered Person pays towards their Out-of-Network Deductible **do not** count towards satisfying the In-Network Deductible.

EXCEPTIONS:

The Plan Year Deductible applies to all Covered Services except the following:

- Routine Nursery Care
- Childhood Immunizations
- Routine & Diagnostic Mammogram, breast MRI or breast ultrasound and any associated lab services
- In-Network Preventive Care Services
- Annual Prostate Screening
- Routine digital rectal exam
- Physician services which are subject to the office visit co-pay
- Transplants, certain Cardiac Care, certain Spinal Surgeries, Hip & Knee Replacements and Cellular Immunotherapy that require the use of a Blue Distinction Center.

Additional Deductibles/Penalties (as applicable):

Inpatient Hospital Preauthorization Penalty (Deductible):	**$1,000** per admission when using an Out-of-Network provider and Preauthorization is not obtained, as required. This penalty will be waived if admission is Preauthorized by the Claims Administrator. Amounts paid towards this Deductible do not apply towards the Maximum Out-of-Pocket Limit.

Dependent Child Deductible Reimbursement Program:

- If your covered Dependent child meets more than **50%** of their In-Network Plan Year Deductible during the Plan Year, you can apply for a reimbursement from the Health Plan for the amount they met between **50%** and **100%** of the Plan Year Deductible.
- To apply, simply complete the **Reimbursement for Dependent Child Deductible** form, which you can print from the Plan's website or obtain from the Plan Administration Office, then mail to the Plan Administration office along with a copy of your recent Explanation of Benefits from BlueCross and BlueShield showing the total amount of Deductible that has been met for that Dependent child.
- Upon approval, a reimbursement check will be mailed directly to you.
- The maximum reimbursement per Plan Year is **50%** of the In-Network Plan Year Deductible, per child. You must apply for the reimbursement no later than **3** months after the end of the Plan Year (e.g. September 30th).

Co-Insurance:

Once you have met your applicable Deductible, you then enter the Co-Insurance phase of your coverage. This means that you pay a portion of the Allowable Charges and the Plan pays a portion of the Allowable Charges for Covered Services.

Two Co-Insurance levels are provided under the Plan, as follows:

1. In-Network Co-Insurance:	You pay **20%** of the Allowable Charges for Covered Services provided by an In-Network Provider (or a BlueCard Provider outside of the state of Oklahoma), up to a maximum of **$4,000**. Any amounts a Covered Person pays towards their In-Network Co-Insurance **do not** count towards satisfying their Out-of-Network Co-Insurance.
2. Out-of-Network Co-Insurance:	You pay **30%** of the Allowable Charges for Covered Services provided by a Provider who is neither a Network

Provider or a BlueCard Provider, up to a maximum of **$8,000**, however, charges are subject to Balance Billing by an Out-of Network Provider.

Any amounts a Covered Person pays towards their Out-of-Network Co-Insurance **do not** count towards satisfying their In-Network Co-Insurance.

Out-of-Pocket Limit

This is the most you could pay during a Plan Year for your share of the cost of Covered Medical Services.

1. **In-Network Maximum Out-of-Pocket Limit:**

$5,000 Individual / **$10,000** Family of **2** or more. Once the In-Network Maximum 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 Plan Year for Covered Services you receive from In-Network Providers. This limit includes the Plan Year Deductible, Co-Insurance and Office Visit and Emergency Room Co-Pays.

Any amounts a Covered Person pays towards their In-Network Maximum Out-of-Pocket Limit **cannot** be used to satisfy their Out-of-Network Maximum Out-of-Pocket Limit.

2. **Out-of-Network Maximum Out-of-Pocket Limit:**

$10,000 Individual / **$20,000** Family of **2** or more. Once the Out-of-Network Maximum 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 Plan Year for Covered Services you receive from Out-of-Network Providers. This limit includes the Plan Year Deductible, the Emergency Room Co-Pay and Co-Insurance. However, 100% of amounts charged above the Allowable Charges for Covered Services will remain the responsibility of the Member.

Any amounts a Covered Person pays towards their Out-of-Network Maximum Out-of-Pocket Limit **cannot** be used to satisfy their In-Network Maximum Out-of-Pocket Limit.

The Maximum Out-of-Pocket Limit for medical services **does not** include:

- Premiums
- Preauthorization Penalty and/or BVA Penalty
- Prescription Drug Co-Pays
- Balance Billing (Charges in excess of the Allowable Charges)
- Dental Benefit Services
- Services not covered by the Plan

Free Major Medical Care/Surgeries

Covered Members will pay zero out-of-pocket for the following procedures, but they must utilize a **Blue Distinction Center** provider. Benefits for these major surgeries are **not covered** under the Plan if a member uses a provider that is not a Blue Distinction Center provider. Visit **www.opehw1.com/healthPlan_Diamond.html** for detailed information**.**

- Transplants
- Certain Cardiac Care
- Certain Spinal Surgeries
- Hip & Knee Replacements
- Cellular Immunotherapy

Before seeking treatment for any of the above procedures, you must call the Customer Service number on your BlueCross and BlueShield ID card to find a provider that is part of a Blue Distinction Center. For a list of applicable procedure codes that require the use of a Blue Distinction Center in order to be covered, refer to the Plan's website at **www.opehw1.com**. However, this list can change periodically, so it is best to call Customer Service.

Members also pay zero out-of-pocket for **Maternity Care** if they use a **Blue Distinction Center**, but it is not mandatory. Use of a provider that is not a Blue Distinction Center will be subject to the plan's deductible and coinsurance.

Plan Year Maximum Benefit Limit: Unlimited

Lifetime Maximum Benefit Limit: Unlimited

Schedule of Medical Benefits

The following schedule shows what Co-Insurance percentage of the Allowable Charge you would pay for Covered Medical Services under the Plan, for both In-Network and Out-of-Network claims. For Out-of-Network claims, please be aware that you would pay your Co-Insurance percentage plus any amount that was over the Allowable Charge (called Balance Billing). The percentages below apply only after any applicable Co-Pay and/or Deductible have been satisfied.

Co-Insurance Percentages you Pay for Covered Services

Covered Medical Services (Subject to the "Covered Medical Services" section which follows)	In-Network %	Out-of-Network % (Subject to Balance Billing)
Accidental Injury Services for Covered Dependent Children - 1st $500 When Covered Services are due to an Accident and received in an emergency room, urgent care facility or minor emergency center; Can be reimbursed up to $500 per Plan Year; Must request reimbursement from the Plan Administration office.	**0%** **After Claim Reimbursement**	**0%** **After Claim Reimbursement**
Accidental Injury Services for Covered Dependent Children - After 1st $500 When Covered Services are due to an Accident and received in an emergency room, urgent care facility or minor emergency center; Claims in excess of $500 per Plan Year.	**20%**	**20%**
Ambulance Services	**20%**	**20%**
Ambulatory Surgical Facility Services	**20%**	**30%**
Bariatric Surgery Requires Preauthorization & Requires the use of a Blue Distinction Center. Benefits are NOT covered if a provider is used that is not a Blue Distinction Center. Does not include any pre or post surgery claims or visits, only facility and professional claims related to the surgery itself. LIMITATIONS APPLY, see page 58.	**20%**	**N/A**
Durable Medical Equipment	**20%**	**30%**
Durable Medical Equipment when using ConnectDME	**FREE**	**N/A**

Co-Insurance Percentages you Pay for Covered Services

Covered Medical Services (Subject to the "Covered Medical Services" section which follows)	In-Network %	Out-of-Network % (Subject to Balance Billing)
Emergency Care Services	**20%**	**20%**
Home Health Care Services Requires Preauthorization	**20%**	**30%**
Hospice Services Requires Preauthorization	**20%**	**30%**
Hospital Services Inpatient Hospital services require Preauthorization.	**20%**	**30%**
Mastectomy & Reconstructive Surgical Services	**20%**	**30%**
Maternity Services	**20%**	**30%**
Maternity Services received at a Blue Distinction Center	**FREE**	**N/A**
Medical/Surgical Services		
Physicians' Office Visits	**0%***	**30%**
All Other Covered Medical/Surgical Services	**20%**	**30%**
Medical Care/ Major Surgeries for: **Human Organ, Tissue & Bone Marrow Transplants, certain Cardiac Care, certain Spine Surgeries, Hip & Knee Replacements and Cellular Immunotherapy:** Requires Preauthorization & Requires the use of a Blue Distinction Center. Benefits are NOT covered if a provider is used that is not a Blue Distinction Center. Does not include any pre or post surgery claims or visits, only facility and professional claims related to the surgery itself. Not applicable to emergencies. Members must call BlueCross and BlueShield Customer Service to check coverage for their procedure and find a Blue Distinction Center Provider.	**FREE**	**N/A**
Orthotic Devices	**20%**	**30%**

Co-Insurance Percentages you Pay for Covered Services

Covered Medical Services (Subject to the "Covered Medical Services" section which follows)	In-Network %	Out-of-Network % (Subject to Balance Billing)
Outpatient Diagnostic Services	**20%**	**30%**
Outpatient Therapy Services	**20%**	**30%**
Preventive Care Services	**0%**	**30%**
Private Duty Nursing Services Requires Preauthorization	**20%**	**30%**
Prosthetic Appliances	**20%**	**30%**
Psychiatric Care Services Requires Preauthorization	**20%**	**30%**
Rehabilitation Care Requires Preauthorization	**20%**	**30%**
Skilled Nursing Facility Services Requires Preauthorization	**20%**	**30%**
Wigs or Other Scalp Prostheses	**20%**	**30%**

*Applicable only to Covered Services which **are** subject to the office visit Co-Pay. For services which **are not** subject to the office visit Co-Pay, this percentage amount is increased to **20%** of Allowable Charges after satisfaction of the Plan Year Deductible.

Member Rewards Program

Members can earn cash rewards for certain healthcare procedures, which can help offset some of a member's out-of-pocket costs. However, there are even cash rewards available for procedures that are already a free service (like routine mammograms and colonoscopies, etc). Rewards range from $25 up to $500. No forms to fill out, it's easy!

Whenever a doctor suggests a medical procedure or service:

- Call **800.672.2567** (the number on the back of your BCBSOK member ID card).
- Tell the Health Advocate about your upcoming procedure or service.
- Select a location for your procedure or service which has a reward.
- Once the claim is paid, receive your reward check in the mail.

Or

- Log into **Blue Access for Members** at **www.BCBSOK.com** (or on your mobile app)
- Click the Doctors and Hospitals tab – then click Find a Doctor or Hospital.

- Search to compare choices and select a reward eligible location.
- Select a location for your procedure or service which has a reward.
- Once the claim is paid, receive your reward check in the mail.

Covered Medical Services

This section lists the Covered Medical Services payable under the Plan. **Services must be Medically Necessary in order to be covered under the Plan, except as otherwise provided.**

Refer to the "Schedule of Medical Benefits" in the previous section to determine what your Co-Insurance would be for these services.

Accidental Injury Services for Dependent Children

- **First $500**
  - If a Covered Dependent child receives Covered Services in an emergency room, urgent care facility or minor emergency center for an Accidental Injury, the Plan will reimburse you for the first **$500** of your out-of-pocket costs for the claim, or, if your out-of-pocket costs for the claim are less than **$500**, the lesser amount. Reimbursement is for services resulting from the initial visit only.
  - To apply for this reimbursement, simply complete the **Reimbursement for Dependent Child Accidental Injury** claim form, which you can print from the Plan's website or obtain from the Plan Administration office, attach a copy of the BlueCross and BlueShield Explanation of Benefits showing the Accidental Injury Services, then mail both items to the Plan Administration office.
  - Upon approval, the Plan will then have the Claims Administrator adjust the claim(s) to accommodate the approved benefit.
  - You must apply for the reimbursement no later than **3** months after the end of the Plan Year.
  - Maximum reimbursement of **$500** per Plan Year per covered Dependent child.
- **After the first $500**
  - For charges in excess of **$500**, Covered Services for an Accidental Injury for a covered Dependent child received in an emergency room, urgent care facility or minor emergency center are subject to Deductible and Co-Insurance.

Ambulance Services

Medically Necessary transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured:

- From your home to a Hospital;

- From the scene of an accident or medical emergency to a Hospital;
- Between Hospitals;
- Between a Hospital and a Skilled Nursing Facility; or
- From the Hospital to your home.

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

Ambulatory Surgical Facility Services

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

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

Bariatric Surgery

Bariatric surgery is subject to Preauthorization and must be performed at a Blue Distinction Center.

Coverage only available to covered members and spouses, not available for dependent children, and subject to the following criteria:

- Individual must be enrolled in health coverage through a Participating Governmental Agency for **2** consecutive years;
- Coverage only available at a Blue Distinction Center;
- Coverage only available for Lap Bands and Gastric Sleeves for the following procedure codes:
    - Gastric Sleeves: 43775
    - Lap Band: 43770, 43771, 43772, 43773, 43774, 43886, 43887, 43888 & S2083.
- Eligibility subject to Blue Cross and Blue Shields' Medical Policy Criteria;
- Deductible and Co-Insurance will apply;
- Preauthorization required;

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 accessories 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;

  - Visits when re-education or refresher training is Medically Necessary.

  Payment for the coverage required for diabetes self−management training in accordance with this provision shall be required only upon certification by the health care Provider providing the training that the patient has successfully completed diabetes self−management training. Diabetes self−management training and training related to medical nutrition therapy, when provided by a registered, certified, or licensed health care professional, shall also include home visits when Medically Necessary and shall include instruction in medical nutrition therapy only by a licensed registered dietician or licensed certified nutritionist when authorized by the patient's supervising Physician and when Medically Necessary.

Coverage for the equipment, supplies and self−management services specified above shall be provided in accordance with the terms and conditions of the appropriate Benefit section of the Plan (for example**:** "**Durable Medical Equipment**", "**Home Health Care Services**" and "**Prescription Drug Coverage**").

Durable Medical Equipment (see ConnectDME under the "**Making Healthy Cheaper**" section to find out how to get your DME for free)

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

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

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

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

Certain items although durable in nature, may fall into other coverage categories, such as prosthetic Appliances or orthotic devices. Custom fit orthotics cannot be obtained through ConnectDME.

Emergency Care Services

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

- serious jeopardy to the Covered Person's health;

- serious impairment to bodily function; or
- serious dysfunction of any bodily organ or part.

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

What happens if I use an Out-of-Network Provider for Emergency Care?If you use an Out-of-Network Provider for Emergency Care Services, you will not be subject to the higher Co-Insurance amount normally associated with your use of an Out-of-Network Provider. Instead, an eligible claim will be processed at the same Co-Insurance level as an In-Network claim.

Can an Out-of-Network Emergency Care Provider Balance Bill me for their Services?
Yes, an Out-of-Network Provider may Balance Bill you for the difference between the Providers usual charge and the Plan's Allowable Amount.

Employer Sponsored Group Health Screening

Benefit is limited to **$100** per Covered Person per Group Health Screening. Employer will submit charges to the Plan Administrator.

Home Health Care Services

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

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

Home Health Care is subject to the Preauthorization guidelines of the Plan. No Benefits are available for failure to comply with these guidelines for Home Health Care.

The Plan **does not** pay Home Health Care Benefits for:

- Dietician services, except as specified for diabetes self−management training;

- Homemaker services;
- Maintenance therapy;
- Durable Medical Equipment;
- Food or home−delivered meals; or
- Intravenous drug, fluid, or nutritional therapy, **except when you have received Preauthorization from the Claims Administrator for these services.**

Hospice Services

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

Hospice Services are subject to the Preauthorization guidelines of the Plan. No Benefits are available for failure to comply with these guidelines for Hospice Services.

Hospital Services

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

Inpatient hospital services are subject to the Preauthorization guidelines of the Plan. If you fail to comply with these guidelines when using an Out-of-Network provider, Benefits for Covered Services rendered during your Inpatient confinement will be subject to a **$1,000** additional Inpatient Hospital Preauthorization Penalty (Deductible), provided the Claims Administrator determines that Benefits are payable upon receipt of a claim.

- **Bed and Board**

  Bed, board and general nursing service in:

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

- **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 and it’s administration;

  - Sub-dermally implanted devices or Appliances necessary for the improvement of physiological function;
  - Diagnostic Services; and
  - Therapy Services.

- **Emergency Accident Care**

  Outpatient emergency Hospital services and supplies to treat Injuries caused by an Accident.

- **Emergency Medical Care**

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

- **Surgery**

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

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

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

Human Organ, Tissue and Bone Marrow Transplant Services

All transplants are subject to Preauthorization and must be performed by and at a Blue Distinction Center provider.

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

- **Definitions**

  In addition to the definitions listed under the "**Glossary"** section of the Plan, 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 nature of certain care and services under the Plan. Preauthorization is subject to all conditions, exclusions and limitations of the Plan. Preauthorization does not guarantee that all care and services a Covered Person receives are eligible for Benefits under the Plan.

- **Procurement Services**

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

- **Transplant Services**

  Subject to the Exclusions, conditions, and limitations of the Plan, Benefits will be provided for Covered Services rendered by a Blue Distinction Center for the human organ and tissue transplant procedures set forth below:

  - Musculoskeletal Transplants;
  - Parathyroid Transplants;
  - Cornea Transplants;
  - Heart−Valve Transplants;
  - Kidney Transplants;
  - Heart Transplants;
  - Single Lung, Double Lung and Heart/Lung Transplants;
  - Liver Transplants;
  - Intestinal Transplants;
  - Small Bowel/Liver or Multivisceral (Abdominal) Transplants;
  - Pancreas Transplants;
  - Islet Cell Transplants; and
  - Bone Marrow Transplants.

- **Exclusions and Limitations applicable to Organ/Tissue/Bone Marrow Transplants**

  The transplant must meet the criteria established by the Claims Administrator for assessing and performing organ or tissue transplants, or Bone Marrow Transplant procedures, as set forth in the Claims Administrator's written medical policies. In addition to the Exclusions set forth elsewhere in the Plan, **no** Benefits will be provided for the following organ or tissue transplants or Bone Marrow Transplants or related services:

  - Adrenal to brain transplants.
  - Allogeneic islet cell transplants.
  - High−Dose Chemotherapy or High−Dose Radiation Therapy if the associated autologous or allogeneic Bone Marrow Transplant, stem cell or progenitor cell treatment or rescue is not a Covered Service.
  - Small bowel transplants using a living donor.
  - Any organ or tissue transplant or Bone Marrow Transplant from a non−human donor or for the use of non−human organs for extracorporeal support and/or maintenance.
  - Any artificial device for transplantation/implantation, except in limited instances as reflected in the Claims Administrator's written medical policies.
  - Any organ or tissue transplant or Bone Marrow Transplant procedure which the Claims Administrator considers to be Experimental or Investigational in nature.
  - Expenses related to the purchase, evaluation, Procurement Services, or transplant procedure if the organ or tissue or bone marrow or stem cells or progenitor cells are sold rather than donated to the Covered Person recipient.
  - All services, provided directly for or relative to any organ or tissue transplant, or Bone Marrow Transplant procedure which is not specifically listed as a Covered Service in the Plan.

The transplant must be performed at a **Blue Distinction Center** by a Provider that meets the criteria established by the Claims Administrator for assessing and selecting Providers in the performance of organ or tissue transplants, or Bone Marrow Transplant procedures.

Accessibility Travel Services for Transplants
Covered Persons will be reimbursed for travel expenses for transportation and lodging that the Covered Person incurs for travel to and from the transplant center that is necessary to obtain any covered medical or behavioral health service rendered by a Blue Distinction Provider if there is no Blue Distinction Provider able to perform that service located within 100 miles of the Covered Person's home address. Coverage is available for the Covered Person and up to one companion, or, if the Covered Person is under age 18, up to 2 companions. Reimbursement for lodging is limited to **$50** per night for the Covered Person and an additional **$50** per night for each permitted companion (up to **$100** per night). The maximum benefits payable for travel services is limited to **$6,000** for each covered transplant performed. Reimbursement requires sufficient supporting documentation. Meals are not reimbursable. Reimbursement is subject to the service, travel, and reimbursement in accordance with all applicable laws or regulations.

- **Donor Benefits**

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

  - When both the recipient and the living donor are Covered Persons, each is entitled to the Benefits of the Plan.
  - When only the recipient is a Covered Person, both the donor and the recipient are entitled to the Benefits of the Plan. The donor Benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage or other BlueCross and BlueShield coverage or any government program. Benefits provided to the donor will be charged against the recipient’s coverage under the Plan.
  - When only the living donor is a Covered Person, the donor is entitled to the Benefits of the Plan. The Benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage or other BlueCross and BlueShield coverage or any government program available to the recipient. There are no Covered Services for the non−Covered Person transplant recipient.
  - If any organ or tissue or bone marrow or stem cells or progenitor cells are sold rather than donated to the Covered Person recipient, no Covered Services will be provided for the purchase price, evaluation, Procurement Services or procedure.
  - The Plan is not liable for transplant expenses Incurred by donors, except as specifically provided.

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

  Bone Marrow Transplants that are otherwise excluded by the Claims Administrator as Experimental or Investigational are eligible for Benefits if the Bone Marrow Transplant meets all of the following criteria:

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

Mastectomy and Reconstructive Surgical Services

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

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

  However, coverage may be provided for a shorter length of Hospital Inpatient stay where the attending Physician, in consultation with the patient, determines that a shorter period of Hospital stay is appropriate.

- **Coverage for reconstructive breast Surgery performed as a result of a partial or total mastectomy**.

  Covered Services shall consist of the following, when provided in a manner determined in consultation with the attending Physician and the patient:

  - reconstruction of the breast on which the mastectomy has been performed;
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

  - prostheses and physical complications at all stages of mastectomy, including lymphedema.

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

Maternity Services

- Hospital services and Medical/Surgical Services from a Provider, including the services of a certified nurse midwife, to an Employee or the Employee’s covered spouse or covered dependent daughter 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

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

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

- Inpatient care shall include, at a minimum:
    - physical assessment of the mother and newborn infant;
    - parent education regarding childhood immunizations;
    - training or assistance with breast or bottle feeding; and
    - performance of any Medically Necessary and appropriate clinical tests.
- The Plan may provide coverage for a shorter length of Hospital Inpatient stay for services related to maternity/obstetrical and newborn infant care provided:

- The licensed health care Providers determine that the mother and newborn infant meet medical criteria contained within guidelines, developed by or in cooperation with licensed health care Providers, which recognize treatment standards, including, but not limited to, the most current treatment standards of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, that determine the appropriate length of stay based upon:

    - evaluation of the antepartum, intrapartum, and postpartum course of the mother and newborn infant;
    - the gestational age, birth weight and clinical condition of the newborn infant;
    - the demonstrated ability of the mother to care for the newborn infant post discharge; and
    - the availability of post discharge follow−up to verify the condition of the newborn infant in the first **48** hours after delivery; and

- The Plan covers one home visit, within **48** hours of discharge, by a licensed health care Provider whose scope of practice includes providing postpartum care. Such visits shall include, at a minimum:

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

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

*Even if you choose **NOT** to enroll your newborn child in the Health Plan after childbirth, coverage for that child will be included under the mother's maternity benefits (provided the mother is enrolled under this Plan) for **48** hours following a vaginal delivery, or **96** hours following a cesarean section. However, benefits are not provided for an infant of a Dependent child.

Medical / Surgical Services

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

- **Anesthesia**

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

- **Assistant Surgeon**

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

- **Blood Transfusions**

  Including charges for blood, blood plasma and blood expanders.

- **Chelation Procedures**

- **Inpatient Medical Services**

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

  - **Inpatient Medical Care Visits**

    Inpatient Medical Care visits are limited to **1** 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 1 visit or other service per day for each consulting Physician.** Staff consultations required by Hospital rules are excluded.\

  - **Newborn Well Baby Care**

    Routine Nursery Care visits to examine a newborn Covered Person, including charges normally made by a Physician for circumcision, 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.

  - **Audiological Services**

    Audiological services and hearing aids, limited to:

    - **1** hearing aid per ear every **48** months for Covered Persons up to age **18**; and

  - Up to **4** additional ear molds per Plan Year for Covered Persons up to **2** years of age.

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

- **Chiropractic Services**

  Chiropractic care and service for the analysis and adjustment of spinal subluxations or for diagnosis and treatment by manipulation of the skeletal structure for other than fractures and dislocations of the extremities which are clearly indicated by x−ray.

  - Benefits for chiropractic medical services are limited to **10** visits per Plan Year.
  - Benefits for chiropractic manipulative services will be limited to **$500** per Plan Year.

- **Contraceptive Devices**

  Contraceptive devices, including injectables, which are:

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

  *See also the **Preventive Care Services** in this section.*

- **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.

- **Sleep Apnea**

  Services for treatment of or related to sleep apnea, Benefits will be limited to **$2,000** per lifetime per Covered Person. See **ConnectDME** in section "**Making Healthy Cheaper**" for information on **free** sleep studies and respiratory supports.

- **Surgery**

  Payment includes visits before and after Surgery.

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

  - When more than one surgical procedure is performed through more than one route of access during one operation, you are covered for:
    - the primary procedure; plus
    - 50% of the amount payable for each of the additional procedures had those procedures been performed alone.
  - Voluntary Sterilization (male or female), regardless of Medical Necessity, but not for reversals. See the **Preventive Care Services/Contraceptive Services** section for additional information on female sterilization benefits.
  - Incision or excision of tumors, lesions and cysts of the jaw, cheek, lip, tongue, roof or floor of the mouth when pathological examination is required.

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

Human Organ, Tissue & Bone Marrow Transplants, Hip & Knee Replacements, certain Cardiac Care and certain Spinal Surgeries requires preauthorization and must be performed at and by a Blue Distinction Center provider Benefits are **NOT** covered if a provider is used that is not a Blue Distinction Center. Does not include any pre or post surgery claims or visits, only facility and professional claims related to the surgery itself. Not applicable to emergencies. Members must call BlueCross and BlueShield Customer Service to check coverage and find a Blue Distinction Center Provider.

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. Custom fit orthotics cannot be obtained through ConnectDME.

- **Benefits will be provided for the following orthotic devices**:
  - Orthopedic shoes, surgical stockings, lifts, or inserts if specially prescribed by a Physician and specifically built for the Covered Person for treatment of an Injury or Illness in accordance with the Physician's specifications; and
  - Braces for the leg, arm, neck back or shoulder, splints for the extremities, back and special surgical corsets and trusses if specially prescribed by a Physician and specifically for treatment of an Injury or Illness in accordance with the Physician's specifications.

- **Benefits for replacement devices will be provided only when Medically Necessary, as follows:**
  - Orthopedic shoes: Up to **2** pair in every **12** month period;

  - Surgical Stockings: Up to **2** pair every **2** months (medical need for continued use must be documented); and
  - Prosthetic bras: Up to **2** bras every **6** months.
- **Not covered are:**
  - Arch supports and other foot support devices (except for diagnosis of Diabetes);
  - Elastic/Compression stockings (except for diagnosis of Diabetes); and
  - Garter belts or similar devices.

Outpatient Diagnostic Services

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

Outpatient Therapy Services

- Radiation Therapy;
- Chemotherapy;
  - Outpatient Therapy Services do not include oral Chemotherapy or self−injectable Chemotherapy. These Prescription Drugs may be covered under your Prescription Drug Benefits under the Plan.
- Respiratory Therapy;
- Dialysis Treatment;
- Physical Therapy and Occupational Therapy*; and
- Speech Therapy*.

*Benefits for Outpatient Physical Therapy, Outpatient Occupational Therapy and Outpatient Speech Therapy (including visits to the Covered Person's home) are limited to a combined maximum of **60** visits per Plan Year per Covered Person.

Oxygen

Oxygen and its' administration.

Preventive Care Services

- **Preventive Care Services received from In-Network Providers and BlueCard PPO Providers**

are not subject to Deductible, Co-pay, Co-Insurance or dollar maximums. However, if you use a provider that is **not** an In-Network Provider or BlueCard PPO provider, then Out-of-Network Deductibles, Co-Insurance and/or dollar maximums do apply.

- If items or services are submitted as other than Preventive Care Services (e.g. submitted with a medical diagnosis), Covered Services will be subject to applicable Deductible, Co-Pay and Co-Insurance. **For example**, the Health Plan fully covers an unlimited number of preventive diabetes screenings, as necessary. However, if a person is actually diagnosed with diabetes (e.g. medical diagnosis), then Covered Services will be subject to applicable Deductible, Co-Pay and Co-Insurance.

- Benefits will be provided for the following Covered Services:

  - Evidence−based items or services that have in effect a rating of “A” or “B” in the current recommendations of the **U**nited **S**tates **P**reventive **S**ervices **T**ask **F**orce (“USPSTF”). A list of “A” or “B” services can be found on the following website:

    www.healthcare.gov/coverage/preventive-care-benefits/

  - Routine Immunizations for children, adolescents and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. A list of these immunizations can be found on the following website:

    http://www.cdc.gov/vaccines/schedules/index.html

  - Evidenced−informed preventive care and screenings for infants, children, and adolescents provided for in the comprehensive guidelines of the **H**ealth **R**esources and **S**ervices **A**dministration (“HRSA”). A list of these covered services can be found on the following website:

    https://www.aap.org

  - Evidence-based preventive care and screenings for women (not described in items listed above) as provided for in the comprehensive guidelines of the **H**ealth **R**esources and **S**ervices **A**dministration (“HRSA”). These guidelines can be found on the following website:

    www.hrsa.gov/womensguidelines/index.html

    Preventive care services with respect to women also include the following Covered Services:

    - **Breastfeeding support, services and supplies**

      Benefits will be provided for breastfeeding counseling and support services rendered by a Provider for pregnant and postpartum women. Coverage includes:

      - The rental (or, at the Plan’s option, the purchase if it will be less expensive) of manual breast pumps, accessories and supplies from a Network or Out-of-Network Provider, or retail supplier; or

      - Electric breast pumps, accessories and supplies – limited to **2** per Plan Year from an In-Network Provider or contracted Durable Medical Equipment supplier only. Coverage is the cost up to the purchase price **($125 - $150);** or

- Hospital grade breast pump, accessories and supplies – only available for monthly rental from a contracted Durable Medical Equipment supplier. Coverage is up to the purchase price of **$1,000** or **12** months, whichever comes first. Upon end of coverage, unit must be returned to the Durable Medical Equipment supplier.

See **ConnectDME** in section "**Making Healthy Cheaper**" for information on how to receive free breast pumps and accessories.

➢ **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.

The contraceptive drugs and devices listed above may change as the FDA guidelines are modified. Co-Insurance or Co-Pay amounts will not apply to FDA-approved contraceptive drugs and devices on the contraceptive information list.

Note: Prescription contraceptive medications are covered under the "**Prescription Drug Coverage"** section of the Plan.

Examples of Covered Preventive Care Services included are: routine annual physicals, immunizations, well-child care, cancer screening mammograms, bone density testing (age 45 and up), screening for prostate cancer and colorectal cancer, tobacco cessation counseling services, healthy diet counseling and obesity screening/counseling.

Examples of covered single-entity and combination vaccines and immunizations included are: Diphtheria, Haemophilus Influenza Type B, Hepatitis A, Hepatitis B, Herpes Zoster (shingles), Human Papillomavirus (HPV) Measles, Meningococcal, Mumps, Pertussis, Pneumococcal, Polio, Rotovirus, Rubella, Tetanus, Varicella and any other immunization that is required by law for a child.

- o **Allergy injections** are not considered immunizations under this Benefit provision.
- o **Flu (Influenza) shots**: Limited to **1** per Plan Year, except for children age **8** and under where **2** may be necessary.

- 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 above may change as the USPSTF, CDC, and HRSA guidelines are modified. For more information, you may access the BlueCross and BlueShield website at **www.bcbsok.com** or contact Customer Service at the toll−free number listed on your Identification Card.
- Covered Services not included as above may be subject to Deductible, Co-Pay's, Co-Insurance and/or dollar maximums.
- Coverage for the Preventive Care Services specified in the items above shall be provided in accordance with the terms and conditions of the appropriate Benefit section of the Plan (for example: "**Hospital Services**," "**Medical/Surgical Services**," and "**Diagnostic Services**").

Private Duty Nursing Services

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

Benefits for Private Duty Nursing Services are limited to **85** visits per Plan Year per Covered Person and require Preauthorization or no Benefits are available.

Prosthetic Appliances

Devices, along with necessary 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 are covered by the Plan.

Eyeglass lens, soft lens and contact lens are included if prescribed as part of postoperative treatment for cataract extraction.

Implantation or removal of breast prostheses is a Covered Service only in connection with reconstructive breast Surgery performed solely and directly as a result of mastectomy which is Medically Necessary.

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

Psychiatric Care Services

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

- **Inpatient Facility Services**

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

- **Inpatient Medical Services**

  Covered Inpatient Medical Services provided by a Physician or other Provider:
  - Medical Care visits limited to **1** visit or other service per day;
  - Individual Psychotherapy;
  - Group Psychotherapy;
  - Psychological Testing; and
  - Convulsive Therapy Treatment.
    - Electroshock treatment or convulsive drug therapy including anesthesia when given together with treatment by the same Physician or other Provider.

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

- **Outpatient Psychiatric Care Services**
  - Facility and Medical Services
    - Covered Inpatient Facility and Medical Services when provided for the Outpatient treatment of Mental Illness by a Hospital, Psychiatric Hospital, Residential Treatment Center, Physician, or other Provider.
  - Day/Night Psychiatric Care Services
    - Services of a Plan−approved facility on a day−only or night−only basis in a planned treatment program.
  - Drug Abuse and Alcoholism
    - Your Benefits for the treatment of Mental Illness include treatments for drug abuse and alcoholism.

Preauthorization is required for all behavioral health services after **10** visits and subject to the guidelines of the Plan (see "**Important Information about your Medical & Dental Benefits**" section).

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, but only if 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.

Rehabilitation Care is subject to the Preauthorization guidelines of the Plan. When using an Out-of-Network provider, failure to comply with these guidelines will result in a **$1,000** additional Inpatient Hospital Preauthorization penalty (Deductible) for Rehabilitation Care if, upon receipt of a claim, Benefits are payable under the Plan.

Skilled Nursing Facility Services

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

Skilled Nursing Facility Services are limited to **30** days of Inpatient care per Plan Year per Covered Person.

Skilled Nursing Facility Services are subject to the Preauthorization guidelines of the Plan. No Benefits are available for failure to comply with these guidelines for Skilled Nursing Facility Services.

No Benefits are payable:

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

Wigs or Other Scalp Prostheses

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

Medical and Prescription Drug Exclusions & Limitations

(Medical & Prescription Drug Services Not Covered under the Plan)

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

What's Not Covered

Except as otherwise specifically stated, the Plan does not provide Benefits for services, supplies or charges:

1. Which are not prescribed by or performed by or upon the direction of a Physician or other Provider.
2. Which the Claims Administrator determines are not Medically Necessary, except as specified.
3. Which the Claims Administrator determines are Experimental/Investigational in nature.
4. Received from other than a Provider.
5. Which are in excess of the Allowable Charge, as determined by the Claims Administrator.
6. 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:

   a. Pursue your rights under the workers' compensation laws;
   b. Take no action prejudicing the rights and interests of the Plan; and
   c. 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:

   a. 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
   b. Repay the Plan any money recovered from your employer or insurance carrier.
7. 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).

8. For any Illness or Injury suffered after the Covered Person's Effective Date as a result of war or act of war (declared or undeclared) when serving in the military or an auxiliary unit thereto.

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

10. 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.

11. For cosmetic Surgery or complications resulting therefrom, including Surgery to improve or restore your appearance, unless it is:

    a. needed to repair conditions resulting from an accidental Injury; or
    b. for the improvement of the physiological functioning of a malformed body member, except for services related to orthognathic Surgery, osteotomy, or any other form of oral Surgery, dentistry, or dental processes to the teeth and surrounding tissue; or

    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.

12. Received from a member of your immediate family.

13. Received before the Covered Person's Effective Date.

14. 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.

15. Received after the Covered Person's coverage stops.

16. For personal hygiene and convenience items regardless of whether or not recommended by a Physician or other Provider. Examples include: computers; air conditioners; air purifiers or filters; humidifiers; physical fitness equipment, including exercise bicycles or treadmills; or modifications to your home or vehicle.

17. For telephone consultations, email or other electronic consultations, missed appointments, or completion of a claim form.

18. For Custodial Care such as sitters' or homemakers' services, care in a place that serves you primarily as a residence when you do not require skilled nursing, or for rest cures.

19. 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.

20. For routine, screening or periodic physical examinations, except as specified in the "**Covered Medical Benefits**" section.

21. For reversal of any voluntary sterilization procedure, including, but not limited to, vasectomies and tubal ligations.

22. For female contraceptive devices when not prescribed by a licensed Provider, including over-the-counter contraceptive products, except as specified in the “**Prescription Drug Coverage”** section. Contraceptive medications or devices for male use are excluded.

23. For Temporomandibular Joint Dysfunction (TMJ) Surgery, 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.

24. For or related to Inpatient treatment of any non−covered dental procedure, except that coverage shall be provided for Hospital Services, Ambulatory Surgical Facility Services, and anesthesia services associated with any Medically Necessary dental procedure when provided to a Covered Person who is:

    a. severely disabled; or

    b. 8 years of age or under;

    and who has a medical or emotional condition which requires hospitalization or general anesthesia for dental care.

25. For eyeglasses, contact lenses or examinations for prescribing or fitting them, except for aphakic patients (including lenses required after cataract Surgery) and soft lenses or sclera shells to treat disease or injury. Vision examinations not related to the prescription or fitting of lenses will be a Covered Service only when performed in connection with the diagnosis or treatment of disease or Injury. Eye refractions are not covered in any event.

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

27. For hearing aids, tinnitus maskers, or examinations for prescribing or fitting them, except as specified for Covered Persons 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.

28. 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.

29. For treatment of sexual problems not caused by organic disease.

30. 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 (except as provided under the “**Covered Medical Services**” section and/or the “**Making Healthy Cheaper**” applicable free programs); prescription or nonprescription drugs or medications such as vitamins (whether to be taken orally or by injection), minerals, appetite suppressants, or nutritional supplements; and any complications resulting from weight loss treatments or procedures.

31. For drugs and medicines purchased by a Covered Person on an Outpatient basis, with or without a Physician's prescription, including drugs and medicines dispensed in the Physician's office, in the Outpatient department of a Hospital, or other Outpatient setting, except as provided under the "**Prescription Drug Coverage**" section.

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

33. For hippotherapy, equine assisted learning, or other therapeutic riding programs.

34. For which the Provider of service customarily makes no direct charge to a Covered Person.

35. For an infant born to a Dependent child unless and until the child is legally adopted and becomes an Eligible Dependent of the Employee.

36. For newborn care if Dependent coverage is not in effect or is not applied for prior to **31** days after the time of the newborn's birth.

37. For voluntary abortion, when the life of the mother would not be endangered if the fetus was carried to term, except complications resulting therefrom.

38. For inpatient drug and alcohol treatment that is not rendered in a Hospital, Psychiatric Hospital, Residential Treatment Center or other Plan-approved Provider.

39. For replacement or repair of prosthetic devices except as specified.

40. For adoption or surrogate expenses, except as specified.

41. Received from a Skilled Nursing Facility, Home Health Care Agency, Hospice, or rehabilitation facility which is not a Plan−approved Provider.

42. For or related to transplantation of donor organs, tissues or bone marrow, except as specified under ***"Human Organ, Tissue and Bone Marrow Transplant Services"***.

43. For Physician standby services.

44. 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.

45. For ductal lavage of the mammary ducts.

46. 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.

47. For orthoptic training.

48. For thermal capsulorraphy as a treatment of joint instability, including but not limited to instability of shoulders, knees and elbows.

49. For transcutaneous electrical nerve stimulator (TENS unit).

50. For any charges due to use of drugs other than drugs obtained by written prescription of a Physician and used under his/her direction, or expenses incurred due to drug overdose (does not apply to Dependents under age **15)**.

51. Travel, whether or not recommended by a Physician, except as specified.

52. For any charges for services received outside the United States, unless charges are Incurred while traveling on business or pleasure.

53. For any stop smoking treatments or services primarily to stop smoking and includes any stop smoking aids, except as provided under the "**Covered Medical Benefits** or **Prescription Drug Coverage**" sections.

54. Which are not specifically named as Covered Services subject to any other specific Exclusions and limitations in the Plan.

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

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Cost-Sharing Summary for Covered Dental Services

This section summarizes your share of the costs of your Covered Dental Services (as described in the "**Covered Dental Services**" section that follows). Please note that services must be Medically Necessary in order to be covered under the Plan. Check with your Employer Group to find out which Dental plan your Employer Group has selected, if any. The Plan Year is from **July 1** through **June 30**.

In-Network Benefits:	**Enhanced Dental Plan**	**Standard Dental Plan**
Individual Deductible Per Plan year per Covered Person. Does not apply to Preventive & Diagnostic Services or Orthodontic Treatment for Children	**$25**	**$50**
Plan Paid Maximum Per Plan Year per Covered Person	**$2,500**	**$1,500**
Preventive & Diagnostic Services Plan pays **100%** of the Allowable Charges*. Deductible does NOT apply. Subject to Plan Paid Maximum.	**Free**	**Free**
Basic Services Percentage you pay of Allowable Charges*. Subject to Deductible and Plan Paid Maximum.	**15% Coinsurance**	**20% Coinsurance**
Major Services Percentage you pay of Allowable Charges*. Subject to Deductible and Plan Paid Maximum.	**40% Coinsurance**	**50% Coinsurance**
Orthodontic Services Percentage you pay of Allowable Charges*. Available to adults and covered dependent children up to age **26**. Deductible does not apply. **$1,500** Lifetime Plan Paid Maximum per Child.	**50% Coinsurance**	**50% Coinsurance**

*For Out-of-Network Covered Dental Services, the Allowable Charge is the Provider's usual charge, not to exceed the amount that the Plan would reimburse a Participating Dentist for the same services. You will be responsible for the full amount by which the actual charges of an Out−of−Network Dentist exceeds the Allowable Charge. See next page for example.

Example: If your Provider's usual charge for a Covered Dental Service is $200, but the Plan's Allowable Charge for that Covered Dental Service is only $150, then you would be responsible for paying the $50 difference.

Covered Dental Services

This section describes the services and supplies covered by this dental Plan. Benefits are payable only for services and supplies that are considered Medically Necessary, except as otherwise provided.

Care by more than one Dentist

If you should change Dentists in the middle of a particular course of treatment, Benefits will be provided as if you had stayed with the same Dentist until your treatment was completed. There will be no duplication of Benefits.

Alternate Benefit Program

In all cases in which there is more than one course of treatment possible, the Benefit payment will be based upon the course of treatment bearing the lesser cost.

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

Class 1: Preventive and Diagnostic Services

Your Benefits for Diagnostic and Preventive Dental Services are designed to help you keep dental disease from starting or to detect it in its early stages. Your Preventive and Diagnostic Dental Services are as follows:

- **Oral Examinations**: The initial oral examination and periodic routine oral examinations. However, your Benefits are limited to **2** examinations per Plan Year.

- **Dental X-rays:** Benefits for panoramic and routine full−mouth X-rays are limited to **1** full−mouth series every **36** months. Routine bitewing X-rays are limited to **1** set per Plan Year. Additional full−mouth X-rays are covered only if Medically Necessary.

- **Prophylaxis:** The routine scaling and polishing of your teeth. Benefits are limited to **2** cleanings per Plan Year.

- **Topical Fluoride Application**: Benefits for this application are only available to Covered Persons under age **19** and are limited to **2** applications per Plan Year.

- **Sealants:** For permanent **1st** and **2nd** molars free from caries and restorations on the occlusal surface. Benefits for sealants are only available to Dependent children under age **14.**

- **Space Maintainers**: Benefits for space maintainers are only available to Covered Persons under age **19** when not part of orthodontic treatment.

- **Biopsies of the oral tissue.**

- **Labs and Tests:** Pulp vitality tests.

- **Emergency oral examinations and palliative emergency treatment** for the temporary relief of pain.

Class II: Basic Services

- **Maintenance services,** limited to the following:
    - Routine Fillings;
    - Procedures to prevent and treat disease of the dental pulp and gums;
    - Bridge and Denture repairs;
    - Recementation of crowns, inlays/onlays;
    - Stainless steel crowns for primary teeth only; and
    - Home Visits —Visits by a Dentist to your home when medically required to render a Covered Dental Service.

- **Oral surgical services**, limited to the following:
    - Simple extractions;
    - Surgical removal of teeth and maxillary or mandibular intrabony cysts, and preparing the mouth for dentures;
    - Surgical removal of the apex of the tooth root;
    - Removal of a root of a multi−rooted tooth and its related crown position, or a root resection; and
    - General Anesthesia/Intravenous Sedation — If Medically Necessary and administered with a covered dental procedure. The anesthesia must be given by a person who is licensed to administer general anesthesia/intravenous sedation.

- **Diagnosis and treatment of gum disease**, limited to the following:
    - Removal of gum tissue around the necks of the teeth and the recontouring of gum tissue;
    - Removal of diseased gum tissue;
    - Surgery performed on the alveolar bone, including flap entry and closure;
    - Positioning of gum tissue surrounding teeth; and
    - Periodontal scaling of gum tissue and root planning.

Class III: Major Services

- **Complex restorative services**, limited to the following:
    - Inlays (not part of bridge);
    - Onlays (not part of bridge);
    - Crowns (not part of bridge);
    - Veneers or similar properties of crowns and bridges placed on or replacing the **10** upper and **10** lower front teeth.
    - Implants.
- **Full and partial dentures and fixed bridges**.

  Benefits are limited to standard procedures and are not for personalized restoration, specialized techniques in constructing full or partial dentures or fixed bridges or replacement of Appliances that can be made serviceable.
- **Denture adjustments, relining and rebasing**: provided only if done more than **6** months after initial denture placement. Relining or rebasing is limited to once per **36** months.
- **Fixed bridge repairs**.
- **Occlusal guards: 1** per every **5** plan years.
- Replacement of crowns, fixed bridges, and full removable dentures are limited to **1** per **60** months.

Class IV: Orthodontic Treatment

- Orthodontic Treatment benefits are available to adults and covered dependent children up to age **26**.
- **No** Deductible and **no** Waiting Period.
- The plan will pay up to a **$1,500** lifetime maximum per covered child.
- Orthodontic Services are covered at **50%** of Allowable Charges from an In-Network provider. After reaching the lifetime maximum, the member is responsible for **100%** of all additional Orthodontic services received.

Dental Exclusions & Limitations (Dental Services Not Covered under the Plan)

Benefits are not provided under this dental Plan for the following:

1. Services or supplies not specifically listed as a Covered Service, or when they are related to a non−covered service.
2. Dental services which are performed for cosmetic purposes, including but not limited to, bleaching teeth and grafts to improve esthetics.
3. Dental services or Appliances for the diagnosis and/or treatment of Temporomandibular Joint Dysfunction (TMJ) and related disorders or to increase vertical dimension.
4. Dental services which are performed due to an accidental Injury (see the "**Covered Medical Services"** section).
5. Services for gold foil restorations.
6. Services or supplies that do not meet accepted standards of dental practice.
7. Services or supplies which the Plan determines are Experimental/Investigational in nature.
8. Hospital and ancillary charges.
9. Services or supplies for which you are not required to make payment or would have no legal obligation to pay if you did not have this or similar coverage.
10. Services or supplies for which "discounts" or waiver of Deductible or Co-Insurance amounts are offered.
11. Services received from a member of your immediate family.
12. Services or supplies received from someone other than a Dentist, except for those services received from a licensed dental hygienist under the supervision and guidance of a Dentist, where applicable.
13. Services or supplies received for behavior management or consultation purposes.
14. Services for plaque control programs, unless specifically provided.
15. Local anesthesia or analgesia when billed separately.
16. Veneers or similar properties of crowns and bridges placed on or replacing teeth, other than the **10** upper and **10** lower anterior teeth.
17. Replacement of bridges, dentures, or other prosthetic devices or Appliances lost through misplacement, total destruction while not being worn, or theft.

18. Orthodontic services and supplies, except as specified in the "**Covered Dental Services"** section for covered adults and dependent children.

19. Charges for duplicate, temporary or provisional prosthetic device or other duplicate, temporary or provisional Appliances.

20. Orthognathic Surgery or other surgery procedures, unless specifically provided.

21. Charges for prescription or non−prescription mouthwashes, rinses, topical solutions or preparations.

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

23. Prosthetic devices (including bridges and crowns) and their fitting, which were prescribed while you were not covered under the Plan, or which were prescribed while you were covered under the Plan but are finally installed or delivered to you after termination of coverage.

24. For the following non−dental surgical procedures:

  a. Excision of tumors and cysts of the facial bones, cheeks, lips, tongue, roof and floor of mouth when pathological examination is required (see the "**Covered Medical Services"** section);

  b. Excision of tori of hard palate when done as an independent procedure;

  c. Treatment of fractures of facial bones;

  d. External incision and drainage of cellulitis;

  e. Incision of accessory sinuses, salivary glands or ducts; or

  f. Reduction of dislocations.

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

26. Any services, treatments or supplies included as covered services under other hospital, medical and/or surgical coverage.

27. Services and supplies for any illness or injury occurring on or after your Effective Date as a result of war or an act of war, declared or undeclared, when serving in the military or any auxiliary unit thereto.

28. 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 would be obligated to pay any Benefits; and
  - repay the Plan any money recovered from your employer or insurance carrier.

29. Any services or supplies 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).

30. Charges for nutritional, tobacco, and oral hygiene counseling.

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

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

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

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

Prescription Drug Coverage

What you can find in this section:

- **What Pharmacy Network the Plan uses and how to contact them**
- **Online access**
- **Prescription ID cards**
- **Mail Order for Prescription Drugs**
- **Your Benefits & how much you pay for Prescription Drugs**
- **Coverage details**
- **Step-Therapy, Clinical Prior Authorization and Quantity Limitations**
- **Exclusions & Limitations**

Important Information about your Prescription Drug Coverage

What Pharmacy Network does the Plan use?

The Plan uses the Express Scripts pharmacy network. Express Scripts is also the Claims Administrator for the Pharmacy Benefits.

Express Scripts Contact Information and Online Access

You can call Express Scripts Customer Service at **855-315-2460**, or you can log-on to their website at **www.express-scripts.com,** or you can download the mobile app to your smart phone.

The Express Scripts website and mobile app are a great resource. Here are some of things you can do:

- Access your prescription history and recent order status;
- Search for In-Network pharmacies;
- Order replacement ID Cards and/or print a temporary ID Card; the mobile app also has a digital ID card;
- Research Prescription Drug information; and
- Find out Co-pay(s) and coverage details;
- Access the Home Delivery mail order form.

The Mobile App is available for iPhone and Android users. To download the app, search **Express Scripts** in the Apple App Store or Google Play. Message and data rates may apply.

Will I get a Prescription ID Card?

Yes. You will receive an ID Card that is separate from your medical and/or dental card. Your ID Card shows the Plan through which you are enrolled and includes your member ID number. All of your covered Dependents share your ID number. Duplicate cards can be obtained for each member of your family upon request.

Legal requirements govern the use of your card. You cannot let anyone who is not enrolled in your coverage use your card(s). Nor can you let anyone not enrolled in your coverage use your Benefits or receive payment for them.

Additional ID Cards

Whether you just need additional cards for family members or your card has been lost, you can call the Plan Administration office at **1-800-468-5744** to request additional cards, or you can also go to **www.express-scripts.com** and log-in to your Members account to order an ID card(s) directly.

How does my Prescription Drug Plan work?

When you present your ID card to a Participating Pharmacy, your claim will be processed electronically. Your pharmacist will be able to tell immediately which charges count toward your Prescription Drug Co-Pay and will collect the appropriate amount from you at the time of purchase. The pharmacist will then be reimbursed directly by Express Scripts for the balance of covered charges.

Does my Prescription Drug Plan use a Formulary?

Yes, the Health Plan utilizes the Express Scripts drug Formulary, which includes a list of Preferred and Non-Preferred drugs. You can find the Formulary on the Health Plan's website at **www.opehw1.com/healthplan_DiamondChoice.html**.

Does Express Scripts offer Home Delivery for Prescription Medications?

Yes. Express Scripts offers a convenient home delivery program called Worry-Free Fills, delivering medications safely to your door. Worry-Free Fills gives you the peace of mind of knowing that your medication will be refilled and mailed to you automatically when your prescription is within two weeks of running out. This is ideal for maintenance medications (prescriptions you take on a regular basis) to manage conditions such as arthritis, high blood pressure, asthma, or diabetes.

There are **3** options for ordering your prescriptions through Home Delivery:

- **Online**

  The following features are available with the mail order program:

  - Point & Click Online Prescription Ordering;
  - Online Prescription/Order Tracking (USPS & UPS);
  - Email Confirmation of Order Process & Order Shipment;
  - Online Prescription Profile Management;
  - View Last Date Filled; and
  - View Next Eligible Date.

  To register for this service, go to **www.express-scripts.com**.

- **Phone**

  Express Scripts is available 24-hours a day toll free at **855-315-2460**. Please be ready to provide your prescription refill number(s), cardholder ID, year of birth, and your payment information.

- **Mail**

  Mail your prescription to Express Scripts with a completed Express Scripts Home Delivery Order Form. Please enclose payment with your order. You can download a mail order form from the Express Scripts website, from the Health Plan's website (under Forms) or call the Plan Administration office for a copy. Send your order form to:

  Express Scripts
  PO Box 747000
  Cincinnati, OH 45274-7000

How do I get my Specialty Medications?

Specialty Medications are those that are used to treat complex, chronic illnesses such as Rheumatoid Arthritis, Multiple Sclerosis, Hepatitis C or Cancer. Specialty Medications can be obtained through any In-Network retail or mail order pharmacy of your choice. Express Scripts also offers a mail order service for Specialty Medications through Accredo Specialty Pharmacy.

Because Specialty Medications can be more difficult to manage, Accredo Specialty Pharmacy offers the following patient support services at no charge:

- Personalized support to help you achieve the best results from your prescribed therapy;
- Convenient delivery to your home or doctor's office;
- Easy access to a Care Team who can answer medication questions, provide educational materials about your condition, help you manage any potential medication side effects and provide confidential support – all with one toll-free phone call;
- Assistance with your Specialty Medication Refills

You can reach Accredo Specialty Pharmacy at **800.803.2523**

Use of an Out-of-Network Pharmacy

The Plan does not offer coverage for your prescription medications when you use an Out-Of-Network Pharmacy. You will pay for your prescription medications in full.

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Schedule of Prescription Drug Co-Pays

WHAT YOU PAY

Annual Out-of-Pocket Maximum The most you could pay during a plan year for your share of the cost of in-network covered prescription drugs.	**$2,000 / individual** **$4,000 / family of 2 or more**
Brand Name Deductible Per Plan Year, Per Person (not per prescription). Only applies to brand name medications (does NOT apply to brand name covered over-the-counter medications, brand name contraceptives or brand name covered tobacco cessation products).	**$75 / individual**

Prescription Drug Type:	30 Day Supply Retail Pharmacy	90 Day Supply Retail Pharmacy	90 Day Supply Mail Order
Generics	**$10**	**$25**	**$25**
Preferred Brands Brand name Deductible applies (per person, not per prescription).	**$45**	**$112**	**$112**
Non-Preferred Brands Brand name Deductible applies (per person, not per prescription).	**$60**	**$150**	**$150**
Specialty Medications Brand Name Deductible applies. Only available for a 30 day supply. See "Prescription Drug Coverage Details" for more information.	**$10/ $60/ $100** Generic/ Preferred Brand/ Non-Preferred Brand	**N/A**	**N/A**

Prescription Benefit Enhancements:	30 Day Supply Retail Pharmacy	90 Day Supply Retail Pharmacy	90 Day Supply Mail Order
Over-the-Counter (OTC) Proton Pump Inhibitors (PPI) Includes Nexium, Prevacid, Prilosec, Protonix, Omeprazole & Zegerid. **Requires** a prescription. Brand name Deductible does **NOT** apply.	**$0**	**$0**	**N/A**

Prescription Benefit Enhancements Continued:	**30 Day Supply Retail Pharmacy**	**90 Day Supply Retail Pharmacy**	**90 Day Supply Mail Order**
Generic Oral Diabetic Medications	**$5**	**$12**	**$12**
Insulin Specific Preferred Brands only. Check with the Plan Administration Office for the most up-to-date list of included brands. Brand name Deductible does **NOT** apply.	**$25**	**$75**	**$75**
Over-the-Counter (OTC) Anti-Allergy Medications Includes Alavert, Allegra, Claritin, Flonase, Mucinex, Nasacort, Nasonex & Zyrtec. **Requires** a prescription. Brand name Deductible does **NOT** apply.	**$5**	**$12**	**N/A**
Oral Contraceptives & Devices Includes brand names and generics. Includes: oral contraceptives, patches and vaginal rings; all injectable forms of birth control; over-the counter female condoms, spermicides and emergency contraceptives; Diaphragms, with a quantity limit of 1 per year; IUD, with a quantity limit of 1 every 5 years. **Requires** a prescription. Brand name Deductible does **NOT** apply.	**$0**	**$0**	**$0**
Tobacco Cessation Products Limited to a 180 day supply per rolling 365 day period; Includes prescription Chantix and bupropion, buproban (generic Zyban) & OTC gum, patches & lozenges. **Excludes** Brand Zyban and inhaled nicotine. **Requires** a Prescription. Brand name Deductible does **NOT** apply.	**$0**	**$0**	**$0**

Prescription Drug Coverage Details

This section describes the medicines and supplies covered by the Prescription Drug Plan. Benefits are payable only for services which are considered Medically Necessary, except as otherwise provided.

Refer to the “**Schedule of Prescription Drug Co-Pays**” in the previous section to determine what your Co-Pay would be for covered prescriptions.

Covered Prescription Drug Services:

Drugs, Medicines and Supplies

Drugs, medicines, supplies (including medications used for birth control), glucose meter, and dressings which are obtainable by prescription, purchased for use outside a Hospital.

Supplies required for the treatment of diabetes, including insulin, syringes, needles and test-strips are Covered Charges when the following criteria is met:

- Patient has a diagnosis of being an insulin dependent diabetic; and
- The Physician prescribes home monitoring.

Over-the-counter (OTC) Medicines

Limited as provided in the Schedule of Prescription Drug Co-Pays.

Annual Out-of-Pocket Maximum:

$2,000 for an individual, or **$4,000** for a family of 2 or more. This is the most you could pay during a plan year for your share of the costs of in-network covered prescription drugs.

Prescription Costs:

You pay the Prescription Drug Co-Pay (see the **Schedule of Prescription Drug Co-pays**) or, if the full cost of the drug is less than the Co-Pay you pay the lesser amount. For brand name prescriptions **ONLY**, you must also meet the brand name Deductible (see next paragraph for details).

Brand Name Deductible (per Plan Year):

$75 deductible per Plan Year on all brand name medications only. Does not apply to brand name contraceptives, brand name covered over-the-counter medications or brand name covered tobacco cessation products. There is no Deductible on generic prescriptions.

You pay **ONLY 1** Deductible per Plan Year regardless of the number of brand name prescriptions you fill. There is **NOT** a separate brand name Deductible for each brand name prescription you fill.

Specialty Medications:

Specialty Medications can be obtained through any In-Network retail or mail order pharmacy, including the Accredo Specialty Pharmacy through Express Scripts. Specialty Medications can only be dispensed **30** days at a time.

Co-Pays for Specialty Pharmacy Prescriptions are split into 3 tiers based on the type of medication. Generic medications are **$10,** Preferred Brand medications are **$60** and Non-Preferred Brand medications are **$100.** These co-pays are for a **30** day supply. The Brand name Deductible **does** apply.

Compound Medications

The Plan will pay up to **$300** per prescription for a covered, compounded prescription medication. Any amount over that is the responsibility of the member. Compound medications are subject to member co-pay and brand name deductible (if applicable).

Medications Requiring Step-Therapy

Certain medications covered under the Plan require the use of an equally effective and less expensive prescription medication before a more expensive alternative will be considered for coverage.

For a current listing of medications requiring step-therapy, please visit the Plan's website at **www.opehw1.com/rx_stepTherapies.html**

Medications Requiring Clinical Prior Authorization (CPA)

Certain medications require **C**linical **P**rior **A**uthorization (CPA) approval before they will be covered. Types of Clinical Prior Authorizations include, but are not limited to, medications with quantity limitations, age limitations, and/or require clinical determinations for appropriate use. The Plan's Prescription Drug program vendor administers the Clinical Prior Authorization process on behalf of the Plan.

For a current listing of medications requiring a CPA and the approval process and procedures, please visit the Plan's website at **www.opehw1.com/rx_clinicalPriorAuthorizations.html**

Medications with Quantity or Age Limitations

Certain medications require Prior Authorization approval before they will be covered. Types of Prior Authorizations include, but are not limited to, medications which exceed recommended quantity limitations, exceed recommended age limitations, and/or require clinical determinations for appropriate use. The Plan's prescription drug program vendor administers the Quantity & Age Limitation process on behalf of the Plan.

For a current listing of medications with Quantity or Age Limitations and the approval process and procedures, please visit the Plan's website at **www.opehw1.com/rx_quantityAgeRestrictions.html.**

Exclusions & Limitations for Prescription Medications

In addition to the "**Medical and Prescription Drug Exclusions and Limitations**" section, certain special exclusions apply to prescription drug coverage. For a current listing of excluded medications, supplies & devices, please visit the Plan's website at **www.opehw1.com/rx_exclusions.html**

General Plan Provisions for Medical, Dental & Prescription Drug Coverage

This section explains the following:

- **The Benefits to which you are entitled;**
- **Payment of Benefits;**
- **Your relationship with Hospitals, Physicians, and other Providers;**
- **Coordination of Benefits when you have other coverage.**
- **The Plan's right of Recoupment and Subrogation**
- **Use and disclosure of Protected Health Information (PHI)**
- **Discretionary Authority of the Plan Administrator and other Plan Fiduciaries**
- **Amendment and Termination of the Plan**
- **Applicable Law**

Benefits to which you are Entitled

The Plan provides only the Benefits specified in this Benefit Book.

Only Covered Persons are entitled to Benefits from the Plan and they may not transfer their rights to Benefits to anyone else.

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

Prior Approval

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

Notice and Properly Filed Claim

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

Your Properly Filed Claim must be furnished to the Claims Administrator within **180** days of the date of service.

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

Limitation of Actions

No legal action may be taken to recover Benefits until 60 days after a Properly Filed Claim has been made. No such action may be taken later than **2** years after expiration of the time within which a Properly Filed Claim is required by the Plan.

Payment of Benefits

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

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

Once a Provider gives a Covered Service, the Claims Administrator will not honor a request not to pay the claims submitted. Benefits under the Plan will be based upon the Allowable Charge (as the Claims Administrator determines) for Covered Services. An In-Network Provider or Participating Dentist will accept the Allowable Charge as payment in full and will make no additional charge to you for Covered Services. However, if you receive Covered Services from an Out−of−Network Provider, you may be responsible for amounts which exceed the Allowable Charge, in addition to the Deductible and/or Co-Insurance amounts.

Benefits for Services Outside the State of Oklahoma

All BlueCross and BlueShield Plans participate in a national program called the “BlueCard Program”. This national program Benefits Covered Persons who receive Covered Services outside the state of Oklahoma. When you obtain health care services through BlueCard outside the state of Oklahoma, the amount you pay for Covered Services is calculated on the ***lower*** of:

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

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

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

NOTE: BlueCross and BlueShield of Oklahoma may postpone application of your Co-Pay, Deductible and/or Co-Insurance amounts whenever it is necessary so that they may obtain a Provider discount for you on Covered Services you receive outside the state of Oklahoma**.**

Determination of Benefits and Utilization Review

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

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

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

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

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

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

Failure of the Covered Person to comply with the Claims Administrator's request for medical or dental records or medical evaluation may result in Benefits being partially or wholly denied.

Covered Person/Provider Relationship

The choice of a Provider is solely yours.

Providers (including Dentists) are not employees, agents or other legal representatives of BlueCross and BlueShield of Oklahoma.

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

Their reference to Providers as "BluePreferred PPO", "BlueChoice PPO", "BlueCard PPO", or "Out−of−Network" is not a statement or warranty about their abilities or professional competency.

Coordination of Benefits

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

- **Definitions**

  In addition to the definitions found in the "**Glossary"** section of this Benefit Book, the following definitions apply to this provision.

"Other Contract" means any arrangement, except as specified below, providing health care benefits or services through:

- Group, blanket or franchise insurance coverage;
- BlueCross Plan, BlueShield Plan, Health Maintenance Organization, and other prepayment coverage;
- Coverage under labor−management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans;
- Coverage toward the cost of which any employer has contributed, or with respect to which any employer has made payroll deduction; and
- Coverage under any tax supported or government program to the extent permitted by law.

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

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

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

- **Effect On Benefits**

  If the total Benefits for Covered Services to which you would be entitled under the Plan and all Other Contracts exceed the Covered Services you receive in any Plan Year, then the Benefits the Plan provides for that Plan Year will be determined according to this provision.

  When the Plan is primary, we will pay Benefits for Covered Services without regard to your coverage under any Other Contract.

  When the Plan is secondary, the Benefits we pay for Covered Services will be reduced so that the total Benefits payable under the Plan and all Other Contracts will not exceed the balance of Allowable Charges remaining after the Benefits of Other Contracts are applied to Covered Services.

- **Order Of Benefit Determination**

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

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

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

        - If the parent with custody of the child has not remarried, the coverage of the parent with custody pays first.

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

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

        - When none of the above circumstances applies, the coverage you have had for the longest time pays first, except that a contract which covers you as a laid−off or retired employee or as a Dependent of such person pays after a contract which covers you as other than a laid−off or retired employee or Dependent of such person.

    - When the Claims Administrator requests information from another carrier to determine the extent or order of your benefits under an Other Contract, and such information is not furnished after a reasonable time, then the Claims Administrator shall:

        - Assume the Other Contract is required to determine its benefits first;

        - Assume the benefits of the Other Contract are identical to the Benefits of this coverage and pay its Benefits accordingly.

      Once the Claims Administrator receives the necessary information to determine your benefits under the Other Contract and to establish the order of benefit determination under the rules listed above, prior payments under the Plan will be adjusted accordingly (if the above rules require it).

    - If the other carrier reduces your benefits because of payment you received under the Plan and the above rules do not allow such reduction, then the Plan will advance the remainder of its full Benefits under this coverage as if your Benefits had been determined in absence of an Other Contract. **However, the Plan shall be subrogated to all of your rights under the Other Contract.** You must furnish all information reasonably required by the Plan in such event, and you must cooperate and assist the Plan in recovery of such sums from the other carrier.

    - If the other carrier later provides benefits to you for which the Plan has made payments or advances under this Coordination of Benefits provision, you must hold all such payments in trust for the Plan and must pay such amount to the Plan upon receipt.

- **Facility Of Payment**

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

- **Right Of Recovery**

  If we pay more for Covered Services than this provision requires, then the Plan has the right to recover the excess from anyone to or for whom the payment was made. You agree to do whatever is necessary to secure the Plan's right to recover the excess payment.

Plan's Right of Recoupment and Subrogation

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

In addition, if any Benefits are paid to or for a Covered Person under the Plan for an Illness or Injury which occurs through the act or omission of another person or third party, this Plan, to the extent permitted by law, shall be subrogated and succeed to the Covered Person's right of recovery for any medical or dental expenses incurred against (i) any liable person or third party or from any insurer or guarantor of such person or third party; (ii) from any vehicle insurance carrier providing uninsured/underinsured or no-fault motorist coverage or medical payments; or (iii) from any business, professional, or homeowner insurance carrier or other entity providing liability or medical payments. The Covered Person shall pay over to the Plan all sums recovered, by suit, settlement or otherwise, on account of such expenses incurred, but not to exceed the amount of Benefits paid under the Plan. The Plan's subrogation rights are a first priority claim, and the Plan shall be reimbursed out of any type of settlement for payments made under the Plan first, even if all monies recovered from whatever source are insufficient to compensate the Covered Person on part or in whole for all damages sustained.

The Plan may, at its option, take any action to preserve its subrogation rights (including the right to bring a suit in the Covered Person's name against any liable person, third party, or insurer or seek reimbursement out of any amount recovered by the Covered Person). If the Covered Person or the Covered Person's attorney receives any settlement proceeds, such proceeds shall be held in trust for the Plan's benefit. The Plan shall have no obligation to pay any attorneys' or other legal fees to the covered Employee or any covered Dependent's attorney for any subrogation recovery received by the Plan.

As a condition to paying any Benefits under the Plan, the Plan may require the Covered Person to first assign to it any such recovery or right thereto from any third party to the extent that Benefits are payable under the Plan. For purposes of this provision, a recovery which does not specify the matters covered thereby shall be deemed to include a recovery for medical or dental expenses incurred to the extent of any payments made by the Plan.

The Covered Person shall take such action, furnish such information and assistance, and execute such assignments and other instruments as the Plan may require to facilitate enforcement of their rights and interests hereunder. The Covered Person shall also take no action prejudicing such rights and interests.

Failure to comply with the above provisions may result in termination of your coverage and/or legal action to enforce collection.

Use and Disclosure of Protected Health Information

HIPAA requires that the Plan protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices which was provided to you and is available from the Plan Administrator.

The Plan will not use or further disclose information that is protected by HIPAA ("Protected Health Information"), except as necessary for treatment, payment, health Plan operations and Plan administration, or as permitted or required by law. By law, the Plan has required all of its business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of your Employer.

Under HIPAA, you have certain rights with respect to your Protected Health Information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

Discretionary Authority of Plan Administrator and other Plan Fiduciaries

In carrying out their respective responsibilities under the Plan, the Plan Administrator and other Plan fiduciaries shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan Benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Amendment or Termination of the Plan

The Trustees may at any time alter, amend, or terminate the Plan in their sole discretion and the Employer may terminate participation of its Employees, retirees, and their Eligible Dependents at any time in their sole discretion subject to the termination provisions in the Inter-Local Governmental Agreement.

Applicable Law

The Plan shall be construed and interpreted in accordance with the laws of the State of Oklahoma to the extent that those laws are not superseded by federal law.

Claims Procedures for Medical, Dental & Prescription Drug Coverage

What you can find in this section:

- **Claims filing procedures for Medical & Dental**
- **Complaint/Appeal procedures for Medical & Dental**
- **Appeals process for denied post-service Prescription Drug claims**

Claim Filing Procedures for Medical & Dental

The Plan begins to pay only after the Co-Pay and/or Deductible amount you incur toward eligible expenses shows on the Claims Administrator's records. When your Physician, Hospital, or other Provider of health care services submits bills for you, your Co-Pay and/or Deductible will be recorded automatically and then the Plan will begin its share of the payment. If you file your own claims, you must submit copies of all your bills, even those you must pay to meet your Co-Pay and/or Deductible. Then the Claims Administrator's records will show that you have Incurred the Co-Pay and/or Deductible amount, and your health care coverage will begin to help pay the balance of your eligible expenses.

Participating Provider Networks

Participating Providers have agreed to submit claims directly to the Claims Administrator for you. When you receive Covered Services from an In-Network Provider, simply show your Identification Card, and claims submission will be handled for you. If you must use a Provider who is not a member of the Claims Administrator's Network, you should follow the guidelines below in submitting your claims.

REMEMBER….

To receive the maximum benefits under your health and dental care program, you must receive treatment from In-Network Providers.

Hospital Claims

In rare cases when you are admitted as an Inpatient or receive treatment as an Outpatient in a Hospital which does not have an agreement with the Claims Administrator (whether in−state or out−of−state), you ordinary have to pay the Hospital yourself and then file a claim yourself, along with an itemized statement from the Hospital. You will then be paid directly for Covered Services after the Claims Administrator subtracts your Deductible and/or Co-Insurance amounts which apply to your coverage.

Ambulatory Surgical Facility Claims

If you are treated at a facility which does not have an agreement with the Claims Administrator, you ordinary have to pay the Facility yourself and then file a claim yourself, along with an itemized statement from the Facility. You will then be paid directly for Covered Services after the Claims Administrator subtracts your Deductible and/or Co-Insurance amounts which apply to your coverage.

Physician and other Provider Claims

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

Employee-Filed Claims

When you must file a claim yourself, you may obtain claim forms by contacting your Benefit Coordinator, the Claims Administrator or the Plan Administration office.

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

BlueCross and BlueShield of Oklahoma
P.O. Box 3283
Tulsa, Oklahoma 74102−3283

For dental claims, be sure to fill out the dental claim form completely, sign it, and attach the Dentist's itemized statement. Send the completed form to:

BlueCross and BlueShield of Oklahoma
c/o Dental Network of America, Inc.
P.O. Box 23100
Belleville, IL 62223−0100

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.

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

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

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

Deadline for Filing Claims

The Claims Administrator must receive your claims for Covered Services within **180 days** of the date of service.

Benefit Determinations for Properly Filed Claims

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

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

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

The procedure for appealing an adverse Benefit determination is set forth in the section entitled, "**Complaint/Appeal Procedures for Medical & Dental**".

Direct Claims Line

The Claims Administrator has a direct line for medical claims. You may call **800.672.5837** between **8:00 a.m**. and **6:00 p.m**., Monday through Friday, whenever you have a question concerning a claim or your medical coverage.

For questions regarding your dental coverage, you may call a Customer Service Representative at **888.381.9727** between **8:00 a.m**. and **6:00 p.m**., Monday through Friday.

Complaint/Appeal Procedures for Medical & Dental

The Plan 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 either a BlueCross and BlueShield of Oklahoma Customer Service Representative or the Plan Administrator's Office. In most cases, the 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.

**The Plan has established procedures for you to designate an individual to act on your behalf with respect to a Benefit claim or an Appeal of an adverse Benefit determination. A Provider or other health care professional with knowledge of your medical condition is permitted to act as your authorized representative or to bring an Appeal on your behalf.*

If a Claim is Denied or not Paid in Full

On occasion, the Claims Administrator may deny all or part of your claim. There are a number of reasons why this may happen. We suggest that you first read the Explanation of Benefits summary prepared by the Claims Administrator; then review this Benefit Book to see whether you understand the reason for the determination. If you have additional information that you believe could change the decision, send it to the Claims Administrator and request a review of the decision. Include your full name, group and Covered Person identification numbers with the request.

If a claim for Benefits is denied in whole or in part, you will receive a notice from the Claims Administrator within the following time limits:

- For non−urgent pre−service claims, within **15** days after receipt of the claim by the Claims Administrator. A "pre−service claim" is any non−urgent request for Benefits or a determination with respect to which the terms of the Benefit plan require approval of the Benefit in advance of obtaining Medical Care.

- For post−service claims within, **30** days after receipt of the claim by the Claims Administrator. A "Post−service claim" is notification in a form acceptable to the Claims Administrator that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the claim charge, and any other information which the Claims Administrator may request in connection with services rendered to you.

If the Claims Administrator determines that special circumstances require an extension of time for processing the claim, for non−urgent pre−service and post−service claims, the Claims Administrator shall notify you or your authorized representative in writing of the need for extension, the reason for the extension, and the expected date of decision within the initial period. In no event shall such extension exceed **15** days from the end of such initial period. If an extension is necessary because additional information is needed from you, the notice of extension shall also specifically describe the missing information, and you shall have at least **45** days from the receipt of the notice within which to provide the requested information.

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

- The reasons for determination;

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

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

- Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care Provider, claim amount (if applicable), diagnosis, treatment and denial codes with their meanings and the standards used;

- An explanation of the Plan's 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 future notices of claim denials and certain other Benefit information may be available in such non−English language(s);

- 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/expedited clinical claim, a description of the expedited review procedure applicable to such claims. An urgent care/expedited claim decision may be provided orally, so long as a written notice is furnished to the claimant within three days of oral notification; and

- For Benefit determinations relating to urgent care/expedited clinical Appeal (as defined further below), such notice will be provided no later than **24** hours after the receipt of your claim for Benefits, unless you fail to provide sufficient information. You will be notified of the missing information and will have no less than **48** hours to provide the information. A Benefit determination will be made within **48** hours after the missing information is received.

- For Benefit determinations relating to care that is being received at the same time as the determination, such notice will be provided no later than **24** hours after receipt of your claim for Benefits.

An “**urgent care/expedited clinical claim**” is any pre−service claim for Benefits for Medical Care or treatment with respect to which the application of regular time period for making health claim decision 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.

Claim Appeal Procedures - Definitions

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

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 or Investigational or not Medically Necessary or appropriate. If an ongoing course of treatment had been approved by the Claims Administrator and the Claims Administrator reduces or terminates such treatment (other than by amendment or termination of the Plan) before the end of the approved treatment period, that is also an Adverse Benefit Determination. A rescission of coverage is also an Adverse Benefit Determination. A rescission does not include a termination of coverage for reasons related to non−payment of premium.

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

Right to Review Claim Determinations

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

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

- Within **180** days after you receive notice of a denial or partial denial, write to the Claims

Administrator’s Office. The Claims Administrator will need to know the reasons why you do not agree with the denial or partial denial. Send your request to:

Appeal Coordinator − Customer Service Department
BlueCross and BlueShield of Oklahoma
P. O. Box 3283
Tulsa, Oklahoma 74102−3283

- You may also designate a representative to act for you in the review procedure. 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.

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

- In support of your claim review, you have the option of presenting evidence and testimony to the Claims Administrator by phone or in person at a location of the Claims Administrator’s choice. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments and additional medical information within **180** days after you receive notice of an Adverse Benefit Determination or at any time during the claim review process.

  The Claims Administrator will provide you or your authorized representative with any new or additional evidence or rationale and any other information and documents used in the review of your claim without regard to whether such information was considered in the initial determination. No deference will be given to the initial Adverse Benefit Determination. Such new or additional evidence or rationale will be provided to you or your authorized representative sufficiently in advance of the date a final decision on Appeal is made in order to give you a chance to respond. The Appeal will be conducted by individuals associated with the Claims Administrator and/or by external advisors, but who were not involved in making the initial denial of your claim.

  Before you or your authorized representative may bring any action to recover Benefits, the claimant must exhaust the Appeal process and must raise all issues with respect to a claim and must file an Appeal or Appeals and the Appeals must be finally decided by the Claims Administrator or the Plan Administrator.

  If you have any questions about the claims procedures or the review procedure, write to the Claims Administrator’s office or call the toll−free Customer Service number shown in this Benefit Book or on your Identification Card.

Urgent Care/Expedited Clinical Appeals

If your situation meets the definition of an urgent care/expedited clinical Appeal, you may be entitled to an Appeal on an expedited basis. An urgent care/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. Before authorization of Benefits for an ongoing course of treatment is terminated or reduced, the Claims Administrator will provide you with notice at least **24** hours before the previous Benefits authorization ends and an opportunity to Appeal. For the ongoing course of treatment, coverage will continue during the Appeal process.

Upon receipt of an urgent care/expedited pre−service or concurrent clinical Appeal, the Claims Administrator will notify the party filing the Appeal, as soon as possible, but no more than **24** hours after submission of the Appeal, of all the information needed to review the Appeal. Additional information must be submitted within **24** hours of request. The Claims Administrator shall render a determination on the Appeal within **24** hours after it receives the requested information.

Notice of Appeal Determination

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

The written notice will include:

- A reason for the determination;
- A reference to the Plan provisions on which the determination is based, or the contractual, administrative or protocol for the determination;
- Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care Provider, claim amount (if applicable), and information about how to obtain diagnosis, treatment and denial codes with their meanings;
- An explanation of the Claims Administrator's external review processes (and how to initiate an external review);
- In certain situations, a statement in non−English language(s) that future notices of claim denials and certain other Benefit information may be available in such non−English language(s);
- 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.

If the Claim Administrator's or your Plan Administrator's decision is to continue to deny or partially deny your claim or you do not receive timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision. Your external review rights are described in the "**Standard External Review**" section below.

If you need Assistance

If you have any questions about the claims procedures or the review procedure, write or call the Claims Administrator at the toll−free number listed on the back of your Identification Card. The Claim

Administrator Customer Service Helpline is accessible from **8:00 a.m**. to **8:00 p.m**., Monday through Friday.

Appeal Coordinator − Customer Service Department
BlueCross and BlueShield of Oklahoma
P. O. Box 3283
Tulsa, Oklahoma 74102−3283

If you need assistance with the internal claims and Appeals or the external review processes that are described below, you may call the number on the back of your Identification Card for contact information.

Standard External Review

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

- **Request for external review.** Within **4** months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination from the Claims Administrator, you or your authorized representative must file your request for standard external review. If there is no corresponding date, **4** months after the date of receipt of such a notice, then the request must be filed by the first day of the **5th** month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

- **Preliminary review.** Within **5** business days following the date of receipt of the external review request, the Claims Administrator must complete a preliminary review of the request to determine whether:

    - You are, or were, covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;

    - The Adverse Benefit Determination or the Final Adverse Internal Benefit Determination does not relate to your failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);

    - You have exhausted the Claims Administrator's internal appeal process unless you are not required to exhaust the internal Appeals process under the interim final regulations. Please read the "**Exhaustion**" section below for additional information and exhaustion of the internal Appeal process; and

    - You or your authorized representative have provided all the information and forms required to process an external review.

  You will be notified within **1** business day after the Claims Administrator completes the preliminary review if your request is eligible or if further information or documents are needed. You will have the remainder of the 4 month Appeal period (or **48** hours following receipt of the notice), whichever is later, to perfect the Appeal request. If your claim is not eligible for external review, the Claims Administrator will outline the reasons it is ineligible in the notice.

- **Referral to Independent Review Organization.** When an eligible request for external review is completed within the time period allowed, the Claims Administrator will assign the matter to an independent review organization (IRO). The IRO assigned will be accredited by URAC or by similar nationally−recognized accrediting organization. Moreover, the Claims Administrator will take action against bias and to ensure independence. Accordingly, the Claims Administrator must contract with at least 3 IROs for assignments under the plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of Benefits.

  The IRO must provide the following:

  - Utilization of legal experts where appropriate to make coverage determinations under the Plan.

  - Timely notification to you or your authorized representative, in writing, of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within **10** business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after **10** business days.

  - Within **5** business days after the date of assignment of the IRO, the Claims Administrator must provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Failure by the Claims Administrator to timely provide the documents and information must not delay the conduct of the external review. If the Claims Administrator fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Within **1** business day after making the decision, the IRO must notify the Claims Administrator and you or your authorized representative.

  - Upon receipt of any information submitted by you or your authorized representative, the assigned IRO must within **1** business day forward the information to the Claims Administrator. Upon receipt of any such information, the Claims Administrator may reconsider the Adverse Benefit Determination or Final Internal Adverse Benefit Determination that is the subject of the external review. Reconsideration by the Claims Administrator must not delay the external review. The external review may be terminated as a result of the reconsideration only if the Claims Administrator decides, upon completion of its reconsideration, to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination and provide coverage or payment. Within **1** business day after making such a decision, the Claims Administrator must provide written notice of its decision to you and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the Claims Administrator.

  - Review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Claims Administrator's internal claims and Appeals process applicable under paragraph (b) of the interim final regulations under section 2719 of the Public Health Service (PHS) Act. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

  - Your medical records;
  - The attending health care professional's recommendation;
  - Reports from appropriate health care professionals and other documents submitted by the Claims Administrator, you, or your treating Provider;
  - The terms of your plan to ensure that the IRO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law;
  - Appropriate practice guidelines, which must include applicable evidence−based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
  - Any applicable clinical review criteria developed and used by the Claims Administrator, unless the criteria are inconsistent with the terms of the plan or with applicable law; and
  - The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

- Written notice of the final external review decision must be provided within **45** days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the Claims Administrator and you or your authorized representative.
- The notice of final external review decision will contain:
  - A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care Provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
  - The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
  - References to the evidence or documentation, including the specific coverage provisions and evidence−based standards, considered in reaching its decision;
  - A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence−based standards that were relied on in making its decision;
  - A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Claims Administrator or you or your authorized representative;

    - A statement that judicial review may be available to you or your authorized representative; and

    - Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

  - After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the Claims Administrator, State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws, and you or your authorized representative.

- **Reversal of Plan's decision.** Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Claims Administrator must immediately provide coverage or payment (including immediately authorizing or immediately paying Benefits) for the claim.

Expedited External Review

- **Request for expedited external review.** The Claims Administrator must allow you or your authorized representative to make a request for an expedited external review with the Claims Administrator at the time you receive:

  - An Adverse Benefit Determination, if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal Appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal Appeal; or

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

- **Preliminary review.** Immediately upon receipt of the request for expedited external review, the Claims Administrator must determine whether the request meets the reviewability requirements set forth in the "**Standard External Review**" section above. The Claims Administrator must immediately send you a notice of its eligibility determination that meets the requirements set forth in "**Standard External Review**" section above.

- **Referral to independent review organization.** Upon a determination that a request is eligible for external review following the preliminary review, the Claims Administrator will assign an IRO pursuant to the requirements set forth in the "**Standard External Review**" section above. The Claims Administrator must provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

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

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

Exhaustion

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

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

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

Interpretation of the Plan's Provisions

The Plan has given the Claims Administrator the initial authority to establish or construe the terms and conditions of the Plan and the discretion to interpret and determine Benefits in accordance with the Plan's provisions, provided the Board of Review shall have the final authority to interpret and determine matters involving the Plan.

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

All powers to be exercised by the Claims Administrator, the Plan Administrator and Board of Review shall be exercised in a non−discriminatory manner and shall be applied uniformly to assure similar treatment to persons in similar circumstances.

Appeals Process for Denied Post-Service Prescription Drug Claims

The Plan has established the following process to review your Appeals. If you have designated an authorized representative*, that person may act on your behalf in the Appeals process.

If you have a question or complaint, an initial attempt should be made to resolve the problem by directly communicating with either an Express Scripts Customer Service Representative or the Plan Administration office. In most cases, a Customer Service Representative will be able to provide you with a satisfactory resolution 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.

**The Plan has established procedures for you to designate an individual to act on your behalf with respect to a Benefit claim or an Appeal of an adverse Benefit determination. A Provider or other health care professional with knowledge of your medical condition is permitted to act as your authorized representative or to bring an Appeal on your behalf.*

Claim Appeal Procedures

The “named fiduciary” for purposes of an appeal of a denied Prescription Drug Post-Service Claim, as described in U. S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000) is **EXPRESS SCRIPTS**, the Pharmacy Benefits Manager.

A Covered Person, or the Covered Person’s authorized representative, may request a review of a denied claim by making written request to the named fiduciary within one hundred eighty (**180**) calendar days from receipt of notification of the denial and stating the reasons the Covered Person feels the claim should not have been denied.

The following describes the review process and rights of the Covered Person:

1. The Covered Person has a right to submit documents, information and comments and to present evidence and testimony.

2. The Covered Person has the right to access, free of charge, relevant information to the claim for benefits.

3. Before a final determination on appeal is rendered, the Covered Person will be provided, free of charge, with any new or additional rationale or evidence considered, relied upon, or generated by the Plan in connection with the claim. Such information will be provided as soon as possible and sufficiently in advance of the notice of final internal determination to give the Covered Person a reasonable opportunity to respond prior to that date.

4. The review takes into account all information submitted by the Covered Person, even if it was not considered in the initial benefit determination.

5. The review by the named fiduciary will not afford deference to the original denial.

6. The named fiduciary will not be:

    a. The individual who originally denied the claim, nor
    b. Subordinate to the individual who originally denied the claim.

7. If original denial was, in whole or in part, based on medical judgment:

    a. The named fiduciary will consult with a professional provider who has appropriate training and experience in the field involving the medical judgment; and

    b. The professional provider utilized by the named fiduciary will be neither:
        i. An individual who was consulted in connection with the original denial of the claim, nor
        ii. A subordinate of any other professional provider who was consulted in connection with the original denial.

8. If requested, the named fiduciary will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

9. The reviewing pharmacist will make a determination on the approval or denial within **30** days of receiving the appeal request and communicate the decision to the appealing party.

The request for review or urgent appeals may be mailed or faxed to:

EXPRESS SCRIPTS
Clinical Appeals Department
PO Box 66588
St. Louis, MO 63166-6588
Phone: 1.844.374.7377
Fax: 1.877.852.4070

Urgent Appeals (defined by law) is a service that, in the opinion of the Covered Person's Physician or Provider, the Covered Person's health is in serious jeopardy or the Covered Person may experience severe pain that cannot be adequately managed without the medication while the Covered Person waits for the decision on the review. These types of appeals are responded to in **72** hours or less. Urgent appeals submitted by mail will not be considered for urgent processing unless a subsequent phone call identifies the appeal as urgent.

Urgent Appeal Phone number is **1.800.753.2851**.

For a Coverage Review Form, contact Express Scripts or the Health Plan.

External Appeal

A Covered Person, or the Covered Person's authorized representative, may request a review of a denied appeal if the claim determination involves medical judgment or a rescission by making written request to the named fiduciary within four (4) months of receipt of notification of the final internal denial of benefits. Medical judgment includes, but is not limited to:

- Medical necessity;
- Appropriateness;
- Experimental or investigational treatment;
- Health care setting;
- Level of care; and
- Effectiveness of a covered expense.

If there is no corresponding date four (**4**) months after the date of receipt of such a notice, then the request must be made by the first day of the fifth month following the receipt of the notice of final internal denial of benefits. {Note: If the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1, or the next day if March 1st falls on a Saturday, Sunday or Federal holiday.}

Right to External Appeal

Within five (**5)** business days of receipt of the request, the claims processor will perform a preliminary review of the request to determine if the request is eligible for external review, based on confirmation that the final internal denial was the result of:

- Medical judgment; or
- Rescission of coverage under this Plan.

Notice of Right to External Appeal

The Plan Administrator (or its designee) shall provide the Covered Person (or authorized representative) with a written notice of the decision as to whether the claim is eligible for external review within one (**1**) business day after completion of the preliminary review.

The Notice of Right to External Appeal shall include the following:

1. The reason for ineligibility and the availability of the Employee Benefits Security Administration at 1.866.444.3272, if the request is complete but not eligible for external review.

2. If the request is incomplete, the information or materials necessary to make the request complete and the opportunity for the Covered Person to perfect the external review request by the later of the following:

   a. The four (4) month filing period; or

b. Within the forty-eight (48) hour time period following the Covered Person's receipt of notification.

Independent Review Organization

For external reviews by an Independent Review Organization (IRO), such IRO shall be accredited by URAC or a similar nationally recognized accrediting organization and shall be assigned to conduct the external review. The assigned IRO will timely notify the Covered Person in writing of the request's eligibility and acceptance for external review.

Notice of External Review Determination

The assigned IRO shall provide the Plan Administrator (or its designee) and the Covered Person (or authorized representative) with a written notice of the final external review decision within forty-five (**45**) days after receipt of the external review request.

The Notice of Final External Review Decision from the IRO is binding on the Covered Person, the Plan and claims processor, except to the extent that other remedies may be available under State or Federal law.

Expedited External Review

The Plan Administrator (or its designee) shall provide the Covered Person (or authorized representative) the right to request an expedited external review upon the Covered Person's receipt of either of the following:

1. A denial of benefits involving a medical condition for which the timeframe noted above for completion of an internal appeal would seriously jeopardize the health or life of the Covered Person or the Covered Person's ability to regain maximum function and the Covered Person has filed an internal appeal request.

2. A final internal denial of benefits involving a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize the health or life of the Covered Person or the Covered Person's ability to regain maximum function or if the final denial involves any of the following:

   a. An admission,
   b. Availability of care,
   c. Continued stay, or
   d. A health care item or service for which the Covered Person received emergency services, but has not yet been discharged from a facility.

Immediately upon receipt of the request for Expedited External Review, the Plan will do all of the following:

1. Perform a preliminary review to determine whether the request meets the requirements in the subsection, Right to External Appeal.

2. Send notice of the Plan's decision, as described in the subsection, Notice of Right to External Appeal.

Upon determination that a request is eligible for external review, the Plan will do all of the following:

1. Assign an IRO as described in the subsection, Independent Review Organization.

2. Provide all necessary documents or information used to make the denial of benefits or final denial of benefits to the IRO either by telephone, facsimile, electronically or other expeditious method.

The assigned IRO will provide notice of final external review decision as expeditiously as the Covered Person's medical condition or circumstances require, but in no event more than seventy-two (**72**) hours after receipt of the expedited external review request. The notice shall follow the requirements in the subsection, Notice of External Review Determination. If the notice of the expedited external review determination was not in writing, the assigned IRO shall provide the Plan Administrator (or its designee) and the Covered Person (or authorized representative) written confirmation of its decision within forty-eight (**48**) hours after the date of providing that notice.

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Vision Coverage

What you can find in this section:

- What vision Provider Network the Plan uses and how to contact them
- How to access your vision Benefits
- Vision ID card - There isn't one!
- Out-of-Network services – what do you pay?
- Your Benefits
- Exclusions & Limitations
- Complaint/Appeal Procedures

Important Information about your Vision Coverage

What Network does the Plan use for Vision Coverage?

The Plan offers vision coverage through **VSP** (Vision Service Plan). Through the nationally renowned VSP Signature Network, you have access to:

- An exceptional doctor Network, with over **34,000** points of access, plus, **87%** of those doctors offer evening and weekend hours.
- One-stop shopping for eyecare and eyewear at all locations
- Savings on quality exams, thousands of frame choices, lens options, and even discounts on laser vision correction.
- Guaranteed Satisfaction - part of VSP's no-hassle member promise program. If you are not completely satisfied with their eyecare services or eyewear, just let VSP know and they'll make it right.
- A website (**www.vsp.com**) where members can view their own Benefits, locate a VSP Network doctor, and find a wealth of information on eyecare and eyewear.

Benefits are furnished under a Vision Care Plan purchased by the Plan and provided by VSP under which VSP is financially responsible for the payment of claims.

What are my Benefits?

The Plan offers two vision plans – an Enhanced Plan and a Standard Plan. Your Employer chooses which vision plan they want to offer to their Employees. To find out which plan your Employer offers, please contact your Employer or the Plan Administrator's office.

Once you know which plan you have (Enhanced or Standard), please refer to the **Schedule of Vision Benefits** for your detailed vision Benefits.

VSP Contact Information & Online Access

You can contact a VSP Customer Service Representative at **1.800.877.7195**, or you can log-on to **www.vsp.com** where you can register as a member to obtain online access. You'll be able to find details about your Benefits, coverage options, when you are next eligible for Benefits, plus find a wealth of information on eyecare or eyewear.

To find a VSP Network Doctor, you can contact VSP at the phone number or website address listed above.

Will I receive an ID Card?

No, there are **no ID cards** with the vision Plan. Simply tell the VSP doctor that you are a member of the VSP Network, provide your name and social security number, and the doctor will handle the rest!

Your Dependent(s) will use your social security number too, and also provide their date of birth for verification.

What if I go to an Out-of-Network Doctor for my Vision Services?

The Plan does offer some limited coverage if you go to an Out-of-Network (non-VSP) Provider. However, VSP cannot guarantee the quality or accuracy of Out-of-Network services, and your Benefits will be substantially reduced.

If you go to an Out-of-Network Provider for services and/or materials, you will be required to pay the Provider in full at the time of service. You can then complete a VSP Member Reimbursement Form to apply for a partial reimbursement directly from VSP. You must file your claim within **6** months of the date of service. Please refer to the **Out-of-Network Reimbursement Schedule** for Out-of-Network reimbursement amounts.

By logging into your VSP account at **www.vsp.com**, you can electronically complete the VSP Member Reimbursement Form online, or you can print the form from the Health Plan's website at **www.opehw.com,** or you can call the Plan Administrator's office to request the form**.**

If you are mailing the Reimbursement Form instead of applying online, then complete the form, attach legible receipts and mail directly to:

VSP
P.O. Box 385018
Birmingham, AL 35238-0518

Upon approval, VSP will mail your reimbursement check to you directly to the address you provided on the VSP Member Reimbursement Form.

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Schedule of Vision Benefits

In-Network Benefits:	**Enhanced Plan**	**Standard Plan**
WellVision Exam®	Once every **12** months for a **$10** Co-Pay	Once every **12** months for a **$10** Co-Pay
Materials Deductible	**$25** (Lenses and/or Frames), Once every **12** months	**$25** (Lenses and/or Frames), Once every **12** months
Lenses (after the Materials Deductible)	Once every **12** months get Single, Lined Bifocal, Lined Trifocal or Standard Progressive Lenses Or, choose Premium Progressive lenses for an **$80-$90** Co-Pay, or Custom Progressive lenses for a **$120-$160** Co-Pay on top of the Materials Deductible	Once every **12** months get Single, Lined Bifocal, Lined Trifocal or Standard Progressive Lenses Or, choose Premium Progressive lenses for an **$80-$90** Co-Pay, or Custom Progressive lenses for a **$120-$160** Co-Pay on top of the Materials Deductible
Lens Options	Polycarbonate Lenses for Dependent Children only, Tints & Dyes and Photochromics are **Fully Covered** Polycarbonate Lenses for Adults are **Discounted 35-40%**	Polycarbonate Lenses for Dependent Children only and Photochromics are **Fully Covered** Tints, Dyes & Polycarbonate Lenses for Adults are **Discounted 35-40%**
Frames	Once every **12** months, **$120** allowance for a wide selection of frames; **$140** allowance for featured frame brands; **20%** savings on any amount you spend over the allowance; **$70** Costco® frame allowance	Once every **24** months, **$120** allowance for a wide selection of frames; **$140** allowance for featured frame brands; **20%** savings on any amount you spend over the allowance; **$70** Costco® frame allowance
Contact Lenses (Instead of Lenses & Frames)	Once every **12** months, **$120** allowance	Once every **12** months, **$120** allowance
Contact Lens Fitting & Evaluation	Once every **12** months, get a **15%** discount off your Contact Lens Fitting & Evaluation and pay a maximum of **$60** (this does not reduce the contact lens allowance)	Once every **12** months, get a **15%** discount off your Contact Lens Fitting & Evaluation. The amount paid on this visit reduces the contact lens allowance

Essential Medical Eye Care

- Pay a $**20 Co-Pay** and receive:
    - **Medical Exams & Services** for diagnosis, evaluation, treatment, & management of chronic conditions, such as diabetic eye disease, glaucoma, dry eye and more.
    - **Treatment for Urgent Conditions** such as eye infections, foreign body & abrasions, eye injuries, & eye or eyelid chemical exposure.
    - **Medical Tests** for diagnosis & treatment of sudden vision changes, such as eye flashes, floaters, & sudden vision loss.
    - **Other Medical Services** which help support optimal vision & eye health, for members experiencing eye disorders or diseases.

TruHearing Hearing Aid Discount Program

Included in both the Enhanced and Standard Vision Plans, at no additional cost, is free membership to the TruHearing ValueAdd Program, which among many other Benefits, offers an average 25% discount on hearing aids. VSP Members can also choose to upgrade with TruHearing to the MemberPlus Program at a reduced rate to enjoy an average 50% savings on hearing aids. Contact VSP for more information or visit **www.vsp.com**.

Other Discounts & Savings

- **Glasses and Sunglasses**
    - Average **35 - 40%** savings on all non-covered lens options.
    - Extra **$20** to spend on featured frame brands. Go to vsp.com/specialoffers for details.
    - **30%** off additional glasses and sunglasses, including lens options, from the same VSP doctor on the same day as your WellVision Exam®. Or get **20%** off from any VSP doctor within **12** months of your last WellVision Exam®.
- **Retinal Screening**
    - Pay no more than **$39** on routine retinal screenings as an enhancement to a WellVision Exam.
    - Members with Diabetes can receive a retinal screening for **$0** per screening.
- **Laser Vision Correction**
    - Average **15%** off the regular price or **5%** off the promotional price. Discounts only available from contracted facilities.
    - After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor.

Limitations on Discounts Listed Above

- Discounts do not apply to vision care Benefits obtained from Out-of-Network Providers.
- **20%** discount applies to complete pairs of glasses only.
- Discounts do not apply if prohibited by the manufacturer.
- Discounts do not apply to sundry items: e.g., contact lens solutions, cases, cleaning products or repairs of spectacle lenses or frames.

Out-of-Network Reimbursement Schedule

If you file a claim for reimbursement within **6** months from the date of service, you may receive reimbursement up-to the following Out-of-Network allowances, after any applicable Co-Pay:

Exam	**$50**	Frames	**$70**
Single Vision Lenses	**$50**	Tints	**$5**
Bifocal Lenses	**$75**	Elective Contacts	**$105**
Trifocal Lenses	**$100**	Medically Necessary Contacts	**$210**
Progressive Lenses	**$75**		

Vision Exclusions & Limitations
(Vision Services Not Covered Through the Plan)

This vision service plan is designed to cover visual needs rather than cosmetic materials. If you select any of the following extras, the Plan will pay the basic cost of the allowed lenses, and you will be responsible for the additional cost for the options, unless the extra is defined in the Schedule of Benefits:

- Optional Cosmetic processes
- Anti-reflective coating
- Color coating
- Mirror coating
- Scratch coating
- Blended lenses
- Cosmetic lenses
- Laminated lenses
- Oversize lenses
- Progressive multifocal lenses
- UV (ultraviolet) protected lenses
- Certain limitations on low vision care

Although a low vision benefit is available to members diagnosed as having severe vision problems (i.e., partial sight), it is subject to limitations. Consult your VSP doctor or VSP for details.

There is no benefit for professional services or material connected with:

- Orthoptics or vision training and any associated supplemental testing; Plano lenses (less than ±.50 Diopter power); or two pair of glasses in lieu of bifocals.
- Replacement of lenses and frames furnished under this Plan which are lost or broken except at the normal intervals when services are otherwise available.
- Medical or surgical treatment of the eyes, unless specified otherwise in the Schedule of Benefits.
- Any eye examination, or any corrective eye wear, required by an employer as a condition of employment.

Complaint/Appeal Procedures for Vision Services

Complaints & Grievances

If you have a question or problem, your first step is to call VSP's Customer Service Department. The Customer Service Department will make every effort to answer your question and/or resolve the matter informally.

If a matter is not initially resolved to your satisfaction, you may communicate a complaint or grievance to VSP, orally or in writing, by using the complaint form that may be obtained upon request from the Customer Service Department. Complaints and grievances include disagreements regarding access to care, or the quality of care, treatment or service. You also have the right to submit written comments or supporting documentation concerning a complaint or grievance to assist in VSP's review. VSP will resolve the complaint or grievance within **30** days after receipt, unless special circumstances require an extension of time. In that case, resolution shall be achieved as soon as possible, but no later than **120** days after VSP's receipt of the complaint or grievance. If VSP determines that resolution cannot be achieved within **30** days, a letter will be sent to you to indicate VSP's expected resolution date. Upon final resolution, you will be notified of the outcome in writing.

Claim Payments and Denials

A. **Initial Determination:** VSP will pay or deny claims within **30** calendar days of the receipt of the claim from you or your authorized representative. In the event that a claim cannot be resolved within the time indicated, VSP may, if necessary, extend the time for decision by no more than **15** calendar days.

B. **Request for Appeals:** If your claim for Benefits is denied by VSP in whole or in part, VSP will notify you in writing of the reason or reasons for the denial. Within **180** days from receipt of such notice of denial of a claim, you may make a verbal or written request to VSP for a full review of such denial. The request should contain sufficient information to identify the Covered Person for whom a claim for Benefits was denied, including the name of the member, member identification number, the Covered Person's name and date of birth, the name of the provider of services and claim number. You may state the reasons you believe that the claim denial was in error. You may also provide any pertinent documents to be reviewed. VSP will review the claim and give you the opportunity to review pertinent documents, submit any statements, documents, or written arguments in support of the claim, and appear personally to present materials or arguments. You or your authorized representative should submit all request for Appeals to:

VSP
Member Appeals
3333 Quality Drive
Rancho Cordova, CA 95670
(800) 877-7195

VSP's determination, including specific reasons for the decision, shall be provided and communicated to you within **30** calendar days after receipt of a request for Appeal from you or your authorized representative.

If you disagree with VSP's determination, you may request a second level Appeal within **60** calendar days from the date of the determination. VSP shall resolve any second level Appeal within **30** calendar days.

Life Insurance Benefits

What you can find in this section:

- What types of life insurance coverage are offered
- Who the life insurance carrier is and how to contact them
- How much you can get and how much it will cost
- Coverage for Dependents
- How to assign a beneficiary

Important Information about your Life Insurance

The Plan offers two types of life insurance options for active, eligible employees and their Dependents:

1. Group Term-Life Insurance
2. Additional Life Insurance (Supplemental Life)

The next few pages will discuss both options. However, for detailed life insurance information and Benefits, you will need to refer to the Plan's Life Insurance vendors Certificate of Insurance, as it shall supersede this Benefit Book. A copy of the Certificate can be obtained, by request, from the Plan Administrator's office.

What Life Carrier (Vendor) does the Plan use & how can I contact them?

The Plan uses MetLife for both the Group Term-Life Insurance and the Additional Life Insurance. You can contact them at the number below:

Customer Service Phone Number: **1.866.492.6983**

Group Term-Life Insurance

What is Group Term-Life Insurance?

Group Term-Life insurance is an Employer-paid Benefit that provides a death Benefit to a Beneficiary(s) if the insured dies. There is no cash value build-up in a term life policy. Each Employer group that participates in the Plan is eligible to offer group term-life insurance to their entire group of eligible Employees.

How much Group Term-Life Insurance will I get and does it include any coverage for my family?

Your Employer chooses how much coverage they want to offer to their Employees. Each Employee within a group will have the same amount of Group Term-Life insurance. Below you will find a chart showing the different amounts that are available for your Employer to offer. You will need to check with your Employers' Benefit Coordinator to determine which amount applies to you.

The Group Term-Life Policy also includes, at no charge to you, term-life coverage for your spouse and/or Dependent children*. The spouse amount is **25%** of the Employee amount, and the Dependent child amount is **10%** of the Employee amount.

Employee Amounts Available:	Spouse Amounts Included (25%):	Dependent Child(ren)* Amounts Included (10%):
$20,000	$5,000	$2,000
$30,000	$7,500	$3,000
$40,000	$10,000	$4,000
$50,000	$12,500	$5,000

Am I automatically approved or will I need to complete a Statement of Health?

This coverage is “guaranteed issue”, meaning that you are eligible for the insurance regardless of your health status. There are no additional forms to complete.

When does my Group Term-Life coverage start?

- If the Employer pays 100% of the premiums for each eligible Employee, then you will be automatically enrolled in this coverage during your initial enrollment with the Plan (or when your Employer group first joins the Plan). Your spouse and/or Dependent children will be automatically enrolled as well. Therefore, it is important that you list your eligible spouse and Dependent children on your enrollment form even if you are not enrolling them in Health coverage.

- If you are not Actively at Work on the date your coverage would otherwise take effect, your life insurance will take effect on the day you resume active work.

Does the Group Term-Life Coverage Reduce as I get older?

Yes, it does. When you reach age **70**, the volume reduces by **50%**. It reduces again at age **80**, down to **25%**.

Are there any other Benefits included with this Group Term-Life Coverage?

Yes, there are some additional Benefits included at no extra cost. These additional Benefits apply **ONLY** to the Employee (not spouse or Dependent children). Here are a few:

- **Accidental Death & Dismemberment Policy Rider**

  Includes a double indemnity provision – should an Employee be killed in an Accident, the policy will pay double the face amount of coverage. Also includes certain Benefits for loss of a limb(s), sight, speech, and hearing. Please refer to the Certificate of Insurance/Schedule of Benefits for information on covered losses and amounts of coverage for such. You can contact the Plan Administrator for a copy of the Certificate of Insurance.

- **Accelerated Death Benefit**

  If an Employee should be diagnosed as terminally ill, then an accelerated payout of a portion of the basic life volume can be obtained to assist with expenses associated with their Illness, or preparations after death.

NOTE: For detailed Group Term-Life Insurance Benefit details, please refer to MetLife Certificate of Insurance, as it shall supersede this Benefit Book. A copy of the Certificate can be obtained, by request, from the Plan Administrator's office or it can also be found on the Plan's website at **www.opehw.com**.

Additional Life Insurance

What is Additional Life Insurance?

This is extra life insurance that you can apply for, in addition to whatever amount your Employer provides under the Group Term-Life Insurance.

Who pays for Additional Life Insurance?

In most cases, you, the Employee, pays for this coverage via payroll deduction.

When can I apply for Additional Life Insurance?

Only during one of the following periods:
- Initial Enrollment Period
- Renewal Period
- Special Enrollment Period

How much Additional Life Insurance can I apply for?

- You can apply for up to **$500,000**, or **5** times your annual salary, whichever is less.
- The minimum you can apply for is **$20,000**, after which it is available in **$5,000** units (unless you are also applying for additional life insurance for your spouse, then your minimum is **$40,000**).
- **First-Time Offering**
  - If this is your **first time to be offered** Additional Life Insurance (initial enrollment) and you apply for more than **$150,000** (if eligible), you will be required to complete a Statement of Health and MetLife's underwriting department will determine whether or not you qualify for the amount above **$150,000**. Any amounts of **$150,000** or less are guaranteed issue, meaning you are automatically approved (not subject to your health status).
  - **Example**: Your annual salary is $25,000. Multiply this by 5 to arrive at the maximum amount you can apply for -- $25,000 x 5 = $125,000. You can apply for up to $125,000 and you do not have to complete a Statement of Health because it is under $150,000.
- **Not the First Offering** (you have previously had the chance to apply for coverage)
  - If this is **not the first time you have been offered** Additional Life Insurance (you were previously

offered and chose not to take the coverage), you may apply for up to **$500,000**, or **5** times your annual salary, whichever is less. Regardless of the amount you apply for, you will be required to complete a Statement of Health and MetLife's underwriting department will determine whether or not you qualify for the amount you have requested.

  - **Example:** Your annual salary is $50,000. Multiply this by 5 to arrive at the maximum amount you can apply for -- $50,000 x 5 = $250,000. You can apply for up to $250,000, but since this is not your initial offering of the Additional Life Insurance, then you will be required to complete a Statement of Health (subject to approval by MetLife) regardless of the amount you apply for.

Can I get Additional Life Insurance for my Spouse?

Yes, if you are applying for or already have Additional Life Insurance for yourself, then you can also apply for Additional Life Insurance for your spouse (subject to the statement of health requirements of the Plan). If you apply for Additional Life Insurance for your spouse, then the minimum that you must have is **$40,000**, as the minimum for your spouse will then be **$20,000** (after which it is available in **$5,000** units). The maximum amount you can get for your spouse is **50%** of your additional life amount, not to exceed $250,000.

- **First-Time Offering for your Spouse**
  - If this is the **first time your spouse has been offered** Additional Life Insurance, you can apply for an amount up to **50%** of your additional life amount, not to exceed $250,000. However, only the first $50,000 is guaranteed issue (no Statement of Health required for approval). Therefore, any amount you apply for between $50,000 and $250,000 is subject to approval of your spouses' Statement of Health. For example, if you have elected **$150,000** of additional life for yourself, then you can apply for up to **$75,000** for your spouse. The first $50,000 will be guaranteed, but the next $25,000 is subject to approval based on your spouse's health.

- **Not the First Offering for your Spouse** (you have previously had the chance to apply for coverage for your spouse)
  - If this is **not the first time your spouse has been offered** Additional Life Insurance (you were previously offered and chose not to take the coverage), then **any** amount you apply for will be subject to approval of your spouses' Statement of Health. The maximum amount you can get for your spouse is **50%** of your additional life amount, not to exceed $250,000.

Can I get Additional Life Insurance for my Dependent Children?

Yes, as long as you are applying for or already have Additional Life Insurance for yourself (subject to the Statement of Health requirements of the Plan). Two coverage amounts are available:

- **$10,000** for **$2.00** per month (total for all eligible Dependent children, not per child), or

- **$20,000** for **$4.00** per month (total for all eligible Dependent children, not per child)

How much does the Additional Life Insurance cost?

The cost is based on age for both Employees and spouses. See the rate table below to determine how much your Additional Life Insurance would cost for every **$1,000** of coverage.

Rate Table
Age-Based cost per every $1,000 of Coverage

$0.07 = Age 34 & Under	**$0.64 = Age 55 to 59**
$0.10 = Age 35 to 39	**$0.74 = Age 60 to 64**
$0.14 = Age 40 to 44	**$1.21 = Age 65 to 69**
$0.23 = Age 45 to 49	**$2.05 = Age 70 to 74**
$0.39 = Age 50 to 54	**$3.18 = Age 75 & Over**

Example: You are 42 years old and apply for $80,000 of Additional Life Insurance. Your age-based cost per every $1,000 of coverage would be $0.14 (from the table above). Now multiply $0.14 x 80 (from the $80,000) = $11.20 per month.

Can I ever increase my Additional Life Insurance?

Yes, you can increase during the Renewal Period or a Special Enrollment Period, but only if you don't go over or are not already at your maximum allowed amount **($500,000** or **5** times your annual salary, whichever is less). If you still have room to increase, then you can do so. You can increase your coverage by $5,000 each year during the Renewal Period without having to complete a Statement of Health. If you want to increase by more than $5,000, then you will be required to complete a Statement of Health and MetLife's underwriting department will determine whether or not you qualify for the additional amount you have requested.

What is an Accidental Death & Dismemberment rider and can I add that to my Additional Life policy?

Yes, you can add the Accidental Death & Dismemberment rider to your Additional Life Policy for an additional premium. The rider includes a double indemnity provision. This means that if you were to be killed in an Accident, the policy will pay double the face amount of your Additional Life coverage. It also includes certain Benefits for loss of a limb(s), sight, speech, and hearing. Please refer to the Certificate of Insurance/Schedule of Benefits for information on covered losses and amounts of coverage for such. You can contact the Plan Administrator for a copy of the Certificate of Insurance.

The cost to add this rider to your policy is **$.03** per every **$1,000** of coverage. It is only available to add to Employee Additional Life Insurance (not spouse or Dependents).

When will my Additional Life Insurance start?

- If applying during the Initial Enrollment Period:
    - If you did not have to complete a Statement of Health, it will start the same time as your other Benefits (health, dental, etc.).
    - If you did have to complete a Statement of Health, then the amount over the guaranteed issue amount will not start until it has been approved by MetLife. If approved, the coverage will be effective the first of the month following the approval date.
- If applying during the Renewal Period:
    - If you did not have to complete a Statement of Health, it will start the beginning of the new Plan year – **July 1st**.
    - If you did have to complete a Statement of Health, then it will not start until it has been approved by MetLife. If approved, the coverage will be effective the first of the month following the approval date.
- If applying during a Special Enrollment Period:
    - If you did not have to complete a Statement of Health, it will start the first of the month after your qualifying event (provided you have notified the Plan or your Benefit Coordinator of the event).
    - If you did have to complete a Statement of Health, then the amount over the guaranteed issue amount will not start until it has been approved by MetLife. If approved, the coverage will be effective the first of the month following the approval date.

Important Information regarding Group Term-Life Insurance and Additional Life Insurance

How do I assign a Beneficiary for the Life Insurance?

There are several ways for you to name a Beneficiary(s) for your life insurance, such as:

- In the Employee Enrollment Form (when you initially enroll in the plan);
- In the Renewal Period Packet; or
- You can request a Beneficiary Change form from your Benefit Coordinator or the Plan Administration office at any time.

You can name multiple Beneficiaries however you choose, either as primary or secondary beneficiaries.

Example #1: You have $20,000 in group term life. In the event of your death, you want your spouse to get the whole $20,000. Therefore, he/she would be the primary Beneficiary at 100% and you would mark as such on the enrollment form.

Example #2: You have $40,000 in group term life. In the event of your death, you want your brother and sister to split the proceeds evenly. You would list them both as a primary Beneficiary, at 50% each. Therefore, they would each get $20,000.

Example #3: You have $30,000 in group term life and $50,000 in Additional Life coverage, for a total of $80,000. In the event of your death, you want your daughter to get the whole $80,000. However, you would like to name a secondary beneficiary just in case your daughter passes away either before or at the same time as you. In this case, the secondary beneficiary you name would get the whole $80,000.

What if I don't name a Beneficiary?

If you do not name a Beneficiary at all, the life insurance company will determine, as described in the policy, who the life proceeds should be paid to.

How do Life Insurance claims need to be filed?

For Employee: In the event of your death, the Plan Administrator will contact the Beneficiary(s) you have named on file and work with them directly to complete the appropriate claim forms and obtain a copy of the certified death certificate, all of which the Plan Administrator will then forward to MetLife for processing and payment.

For Spouse/Dependent Children: In the event of the death of your spouse or Dependent child, the Plan Administrator will contact and work with you directly to complete the appropriate claim forms and obtain a copy of the certified death certificate, all of which the Plan Administrator will then forward to MetLife for processing and payment.

Can I keep my Life Insurance after my coverage with the Plan ends?

After your life coverage ends, you and/or your eligible spouse and Dependent children may be eligible to convert the life insurance you had in place as an active, eligible Employee to an individual whole life policy (new policy) directly with MetLife, regardless of your health.

If you are enrolled in Additional Life, you and/or your eligible spouse may be eligible to port the life insurance you had in place as an active, eligible Employee regardless of your health. The portability option allows you to remain covered under the conditions of the Plan's Term Life insurance policy. Dependent child coverage may also be ported if you, or your spouse, port your life insurance.

For both conversion and portability, there are separate eligibility requirements. Please refer to the Plan's Life Insurance Certificate for eligibility requirements. A copy of the Certificate can be obtained, by request, from the Plan Administrator's office.

Shortly after your coverage with the Plan ends, you will receive a letter regarding the conversion and/or portability options. If you are eligible for both the conversion and portability options on your

Additional Life insurance, you can only continue coverage under one of the options. The letter you will receive will also contain an explanation of the differences between the two options to help you decide which is best for you. As the letter will state, you will have only a certain amount of time to respond and send in your application. After that time period expires, you will lose your conversion and/or portability rights. The conversion and portability applications can be found on the Plan's website at **www.opehw.com**, or you can contact the Plan Administration office to have an application sent to you.

Please refer to the MetLife Certificate of Insurance, as it shall supersede this Benefit Book. A copy of the Certificate can be obtained, by request, from the Plan Administrator's office.

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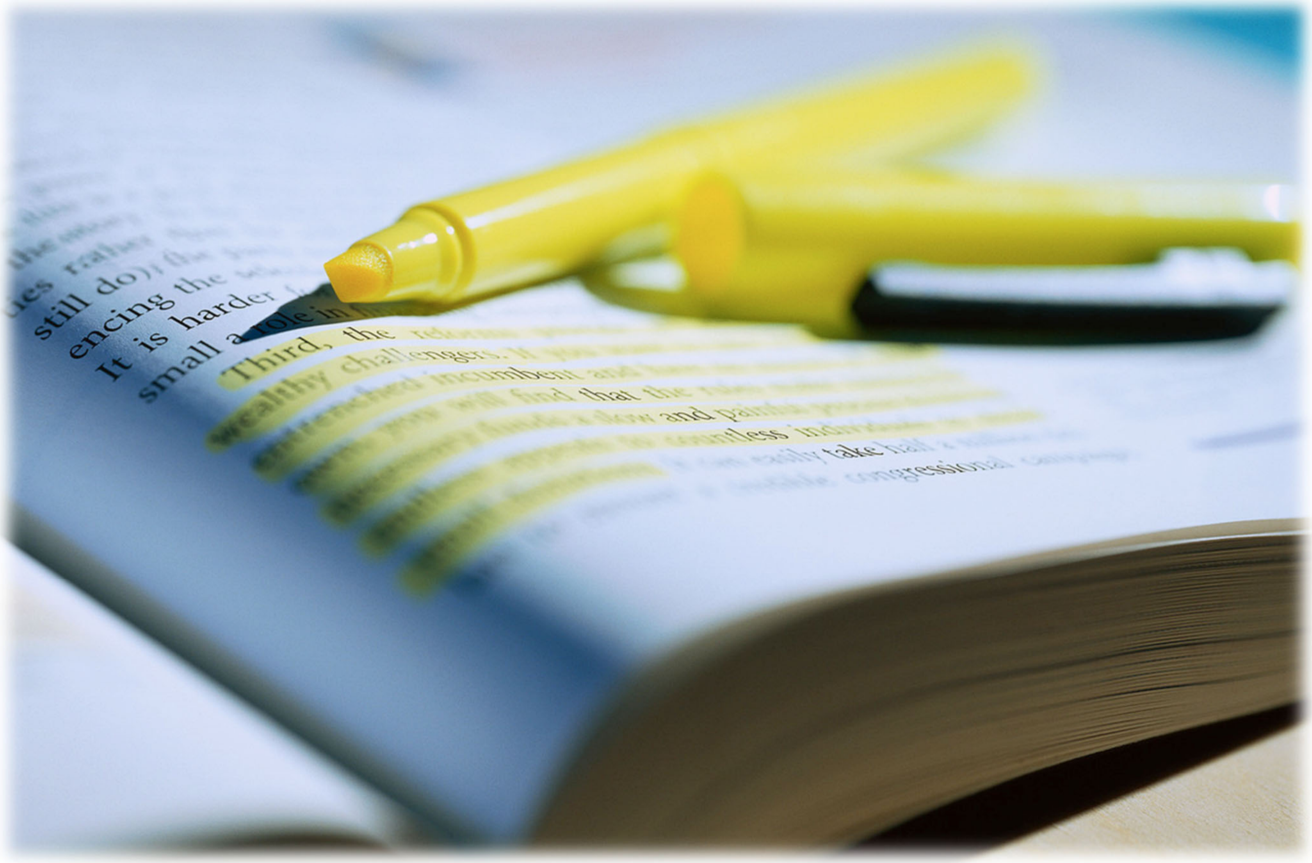
Glossary of Terms Used in this Benefit Book

This section defines certain terms (words) that have been used in this Benefit Book.



Accident (Accidental)

An unexpected happening causing Injury by an external means which is not due to any fault or misconduct on the part of the person injured.

Actively At Work / Active Work

The active expenditure of time and energy in the services assigned by the Employer. You are considered Actively at Work on each day of a regular paid vacation, an Employer holiday, or on a regular nonworking day if you were Actively at Work on the work day before your Effective Date.

Allowable Charge(s) / Allowable Amount

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

- **For Covered Medical Services*,*** the Allowable Charge is determined as follows:
  - **In-Network Provider -** the Provider's usual charge, not to exceed the amount the Provider has agreed to accept as payment for Covered Services in accordance with a BlueCross BlueShield PPO Provider Agreement.
  - **Out−of−Network Provider (Non-Contracting Provider) -** the Provider's billed charge, not to exceed the Claims Administrator's Non−Contracting Allowable Charge as set forth in the ***"Important Information about your Medical & Dental Benefits"*** section.
- **For Covered Dental Services*,*** the Allowable Charge is determined as follows:
  - **Participating Dentists** — the amount the Dentist has agreed to accept as full payment for Covered Services.
  - **Out−of−Network Dentists** — the Dentist's usual charge for Covered Services, not to exceed the amount that the Plan would reimburse a Participating Dentist for the same services.

NOTE: For Covered Services received outside the state of Oklahoma, the "Allowable Charge" will be determined by the BlueCross and BlueShield Plan (Host Plan) servicing the area. Payment will be based upon the Provider payment arrangements in effect between the Provider and the on−site Plan. For Out−of−Network services, the Allowable Charge will be based upon the amount the Host Plan uses for their own local members.

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.

Appeal
A request for the Plan to review a decision or a grievance again.

Appliance
A device used to provide a function or a therapeutic effect (for example: a denture).

Balance Billing (Billed)
This is when a Provider bills you for the difference between the Provider’s charge and the Plan’s Allowable Amount. This is only applicable for Out-of-Network Services, as In-Network Providers cannot balance bill you for Covered Services.

Beneficiary (for Life Insurance)
A natural person or other legal entity who receives money or other benefits from a benefactor. For example: The beneficiary of a life insurance policy is the person who receives the payment of the amount of insurance after the death of the insured.

Benefit Coordinator
The person designated by your Employer as the contact person for insurance (benefit) purposes.

Benefit Period
The period of time during which you receive Covered Services for which the Plan will provide Benefits (also known as the Plan Year)

Benefits
The payment, reimbursement and indemnification of any kind which you will receive or have paid on your behalf from or through the Plan.

BlueCard / BlueCard PPO Provider
The national network of participating PPO Providers who have entered into an agreement with a BlueCross and BlueShield Plan to be a part of the BlueCard PPO program. This is the Preferred Provider Network a person should use when outside the state of Oklahoma to receive the highest level of Benefits under the Plan.

BlueChoice PPO Provider
A Provider who has entered into an agreement with the Medical Claims Administrator to bill the Claims Administrator directly for Covered Services, and to accept the Claims Administrator’s Allowable Charge as payment for such Covered Services.

Blue Distinction Center
Blue Distinction® Centers for Specialty Care are medical facilities recognized for expertise in their field of care. Their focus is on specific high-volume, high-risk and high-cost areas. To be named a Blue Distinction Center, a hospital or medical facility must have a proven history of providing high-quality care with better overall patient results and more affordable prices.

Blue Distinction Centers and Blue Distinction Centers+ designations mean these facilities' overall experience and aggregate data met objective criteria established in collaboration with expert clinicians and leading professional organizations. Individual outcomes may vary.

BluePreferred PPO Provider

A Provider who has entered into an agreement with the Medical Claims Administrator to bill the Claims Administrator directly for Covered Services, and to accept the Claims Administrator's Allowable Charge as payment for such Covered Services.

Board of Review

Those persons representing the Participating Governmental Agencies who have control of the Inter−Local Governmental Agreement, the Trust and the Plan.

Certificate of Coverage / Certificate of Creditable Coverage

A certificate issued by an insurance company that gives written verification of the existence of insurance, dates of coverage, and thus is proof that a person has or has had valid medical insurance.

Change in Status

A Change in Status is an occurrence that dramatically changes the health insurance needs for you or your Eligible Dependents. If you have a Change in Status occur, it allows you to cancel coverage (dis-enroll) to accommodate significant changes without waiting until the Plan's next Renewal Period.

Claims Administrator

The person or entity providing contract claims administration services for the Plan, whose services may include maintaining current Plan data, assisting with billing, underwriting, processing, adjudication and payment of claims, and providing information deemed necessary by the Plan Administrator for the administration of the Plan.

COBRA

This stands for the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

COBRA Continuation Coverage

Coverage available to you and/or your Eligible Dependents who were participating in the Plan but are no longer eligible for coverage under the Plan because of a COBRA qualifying event that has occurred (i.e.: termination of employment, reduction of hours, Dependent child reaching maximum age limit, etc.). This coverage is paid for by you and is only available for a limited period of time. The coverage would be the same coverage that the Plan gives to other similarly situated active participants or beneficiaries under the Plan who are not receiving COBRA Continuation Coverage.

Co-Insurance

This is your share of the costs of a Covered Service, calculated as a percentage of the Allowable Amount (for example, 20%). You pay Co-Insurance plus any Deductibles you owe. For example, if the Plan's Allowable Amount for an In-Network Covered Service is $100 and you've already met your Deductible, your Co-Insurance payment of 20% would be $20. The Plan pays the rest of the Allowable Amount.

Community Home Health Care Agency

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

Compound Medications

Compound medications, which require a prescription from a doctor, are prepared by a pharmacist who mixes or adjusts drug ingredients to customize a medication to meet a patient's individual needs.

Confinement or Confined In A Hospital

A continuous stay in a Hospital Treatment Center, Skilled Nursing Facility, Hospice or birthing center due to an Illness or Injury diagnosed by a Physician. Later stays shall be deemed part of the original Confinement unless there was either complete recovery during the interim from the Illness or Injury causing the initial stay.

Contract Year

The period of 12 months commencing on the first day of July and ending on the last day of the following June. Also referred to as the "Plan Year".

Co-Pay

A fixed dollar amount you pay for a Covered Service, usually at the same time that you receive the Covered Service.

Cosmetic Surgery

Surgery for the restoration, repair, or reconstruction of body structures directed toward altering appearance rather than for the improvement or restoration of bodily function.

Covered Person

An Eligible Employee or Eligible Dependent who is enrolled and covered under the Plan.

Covered Service

A service or supply given by a Provider for which the Plan has specified they will provide Benefits.

Creditable Coverage

Coverage of an individual from a wide range of specified sources, including Group Health Plans, health insurance coverage, Medicare, and Medicaid.

Custodial Care

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

Deductible

A specified amount you are required to pay for Covered Services before the Plan will start to pay its share of the Covered Services. For example, if your Deductible is $750, the Plan won't pay anything until you have met your $750 Deductible for Covered Services that are subject to Deductible. The Deductible may not apply to all services.

Dentist

A professional practitioner who holds a lawful license issued by any state of the United States, or its territories, authorizing the person to practice dentistry and dental surgery in such state or territory, including, but not limited to, a Doctor of Dental Surgery (DDS) or a Doctor of Medical Dentistry (DMD).

Dependent / Eligible Dependent

An Eligible Person other than the Employee as shown in the "**Eligibility, Enrollment, Changes & Termination"** section and also the "**Life Insurance Benefits**" section.

Dependent Child Age Limit

The maximum age a dependent child can be covered under this Health Plan, as shown in the "**Eligibility, Enrollment, Changes & Termination"** section and also in the "**Life Insurance Benefits**" section.

Diagnostic Service

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

- Radiology, ultrasound and nuclear medicine

- Laboratory and pathology

- ECG, EEG, and other electronic diagnostic medical procedures and physiological medical testing, as determined by the Claims Administrator.

Disability (Disabled)

When you are prevented, by Injury or Illness, from engaging in any occupation for wages or profit for which you are reasonably qualified by education, training or experience. "During a Disability," as it applies to you, means all periods of Disability arising from the same cause, including any and all complications therefrom, except that if you completely recover or return to active full−time employment, any subsequent period of Disability from the same cause will be considered a new Disability.

For your Dependent Child, Disabled means a dependent child who is medically certified as disabled and dependent upon the Employee or his/her spouse. A child is a disabled child when the child is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months, per Internal Revenue Code Section 22(e)(3).

Drug or Alcohol Disorder

Any substance abuse, drug addiction, chemical dependency or alcoholism.

Durable Medical Equipment

Equipment and supplies ordered by a health care Provider for everyday or extended use, which meets the following criteria:

- It provides therapeutic benefits or enables the Covered Person to perform certain tasks that he or she would be unable to perform otherwise due to certain medical conditions and/or Illnesses;

- It can withstand repeated use and is primarily and customarily used to serve a medical purpose;

- It is generally not useful to a person in the absence of an Illness or Injury and is appropriate for use in the home; and

- It is prescribed by a Physician and meets the Claims Administrator’s criteria of Medical Necessity for the given diagnosis.

Education Employee

Those Employees other than adjunct professors employed by an Education Entity who are members or are or will be eligible to become members of the Oklahoma Teachers Retirement System and visiting faculty who are not eligible for membership in the Oklahoma Teachers Retirement System.

Education Entity

A school district, a technology center school district or a state institution of higher education.

Effective Date

The date when your Plan coverage begins. Each Employer Group sets their own Effective Date.

Eligibility

The provision of the Plan that states requirements Employees must satisfy to become covered, with respect to themselves or their Dependents.

Eligibility Date

The date on which an Employee becomes eligible to apply for coverage (ie: full-time employment hire date).

Eligibility Period

The time following the Eligibility Date (usually 31 days) during which an Employee is eligible to apply for coverage, depending upon the Employer’s requirements.

Eligible Person

A person entitled to apply for coverage as specified in the “**Eligibility, Enrollment, Changes & Terminations”** section.

Emergency Care

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

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

Employee or Eligible Employee

An Eligible Person as specified in the “**Eligibility, Enrollment, Changes & Terminations”** section.

Employer

A Participating Governmental Agency which has entered into the Inter−Local Governmental Agreement and who has elected to participate in the Plan.

Enroll

To apply for coverage under the Plan, having completed and submitted the required forms to do so.

Enrollment Date

The first day of coverage, or, if there is a Waiting Period, the first day of the Waiting Period (typically the date full-time employment begins). If you apply for coverage during a Renewal Period or during a Special Enrollment Period, your Enrollment Date is your Effective Date of coverage.

ERISA

The Employee Retirement Income Security Act of 1974, as amended. The Plan is not subject to ERISA.

Exclusions

Health care services that the Plan does not pay for or cover.

Experimental/Investigational

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

- The drug, device, biological product, or medical treatment or procedure cannot be lawfully marketed without approval of the appropriate governmental or regulatory agency and approval for marketing has not been given at the time the drug, device, biological product, or medical treatment or procedure is furnished; or

- The drug, device, biological product, or medical treatment or procedure is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or

- The prevailing opinion among peer reviewed medical and scientific literature regarding the drug, device, biological product, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Explanation of Benefits (EOB)

This is a document that the Claim's Administrator prepares after they have processed a claim. The EOB typically provides the following information: the date of service, what services were performed, name of the Provider that performed the services, the Providers' fees, the amount the Claims Administrator allowed for that service, the amount the Plan paid for that service and the amount that you may be responsible for paying. If a claim was denied, the EOB also provides a brief explanation of why it was denied.

Family and Medical Leave Act (FMLA)

The Federal legislation which entitles qualified Employees to take unpaid, job-protected leave for specified family and medical reasons with continued eligibility of group health insurance coverage under the same terms and conditions as if the Employee had not taken leave.

There are qualifications and requirements for this eligibility, including pre−event notification to the Employer and prior employment periods. For more information on this federal legislation, you can visit the United States Department of Labor website at **www.dol.gov** or ask your Employer for more details.

Formulary

A list of prescription drugs covered by a prescription drug plan.

Grievance

A complaint that you communicate to your health plan.

Group Health Plan

An employee benefit plan established or maintained by an employer or by an employee organization (such as a union), or both, to the extent that the plan provides medical care to employees or their dependents or former employees directly or through insurance, reimbursement or otherwise.

Health Insurance Portability and Accountability Act (HIPAA)

The Federal legislation which includes numerous provisions related to Group Health Plans or health insurance carriers.

Home Health Care

A program for continued care and treatment of a Covered Person where health care services are received at home. It must be established and approved in writing by the attending Physician. The Physician must certify that proper treatment would require continued confinement in a Hospital in absence of the services and supplies that are a part of the program of care.

Home Health Care Agency

An agency or organization which meets all of the following requirements:

- It is primarily engaged in and duly licensed to provide skilled nursing services and other therapeutic services;
- It has policies established by a professional group associated with the agency which includes at least one Physician and one Registered Nurse to govern the services provided and it must provide for full−time supervision of such services by a Physician or a Registered Nurse;
- It maintains a complete medical record on each individual; and
- It has a full−time administrator.

Hospice Care

Care and services performed under the direction of your attending Physician in a Plan−approved Hospital Hospice Facility or in−home Hospice program. These services provide comfort and support for persons in the last stages of a terminal Illness and their families.

Hospital

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

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

Hospital Admission

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

Hospitalization

Care in a Hospital that requires admission as an Inpatient and usually requires an overnight stay. An overnight stay for observation could be Outpatient care.

Identification (ID) Card

The card issued to the Employee by the Claims Administrator, bearing the Employee's name, identification number, and the Plan (there are no Identification Cards for the Vision Benefits).

Illness

Any disorder or disease of the body or mind, or Complications of Pregnancy, which are covered under the Plan. All Illnesses due to the same cause or to a related cause will be treated as one.

Incurred

A charge is Incurred on the date you receive a service or supply for which the charge is made.

Independent Review Organization (IRO)

Within the health care industry, an IRO acts as a third-party medical review resource which provides objective, unbiased medical opinions that support effective decision making, based only on medical evidence. IROs deliver conflict-free decisions that help clinical and claims management professionals better allocate healthcare resources and reduce waste.

Initial Enrollment Period

The 31−day period immediately following the date an Employee or Dependent first becomes eligible to Enroll for coverage under the Plan.

Injury

Accidental bodily damage from an Accident(s). All related conditions and recurrent symptoms will be considered as one Injury.

In-Network Benefits (or In-Network Services)

Covered Services which are provided by an In-Network Provider (PPO) and which are covered by the Plan at a level generally higher than Covered Services provided by an Out-of-Network Provider, as shown in the "**Schedule of Medical Benefits**".

In-Network Co-Insurance

The percent (e.g. 20%) you pay of the Allowable Amount for health care services to Providers who contract with the Plan. In-Network Co-Insurance usually costs less than Out-of-Network Co-Insurance.

In-Network Co-Pay

A fixed amount (for example, $20) you pay for Covered Services to Providers who contract with the Plan.

In-Network Provider (PPO Provider)

A BluePreferred, BlueChoice or BlueCard PPO Provider contracted by the Plan to provide services to Covered Persons, which are covered at a level generally higher than Covered Services provided by an Out-of-Network Provider.

Inpatient

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

Intensive Care Unit

A section, ward or wing within a Hospital which is operated exclusively for critically ill patients and provides special supplies, equipment and constant observation and care by Registered Nurses or other highly trained Hospital personnel.

Inter-Local Governmental Agreement or Agreement

The agreement which is adopted by resolution by each of the Employers which have elected to participate in the Plan.

IRO

See Independent Review Organization.

Licensed Practical or Vocational Nurse (LPN or LVN)

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

Lined Bifocal Lens

A type of spectacle or contact lens design that includes two focal areas: one for near and one for distance. Also known as multi-focal lenses.

Lined Trifocal Lens

A type of spectacle or contact lens design that includes three focal areas: usually a reading lens, a lens for far away viewing and a lens for mid-distance viewing. Also known as multi-focal lenses.

Low-Dose Mammography

The x−ray screening examination of the breast using equipment dedicated specifically for mammography, including but not limited to the x−ray tube, filter, compression device, screens, films, and cassettes, with an average radiation exposure delivery of less than one rad mid−breast, with two views for each breast.

Maternity Services

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

Maximum Out-of-Pocket Limit (or Out-of-Pocket Limit)

The maximum amount you could pay during a Plan Year for your share of the cost of covered services. Once the Maximum 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 Plan Year. This limit includes Deductibles, Co-insurance and Copays.

The Maximum Out-of-Pocket Limit **does not include** premiums, Balance Billing, preauthorization penalties, out-of-network prescription drugs, dental benefit services or charges for any services that are not covered under the Plan.

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.

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

Network
The facilities, Providers and suppliers your health plan has contracted with to provide health care services.

Network Pharmacy
A Participating Pharmacy contracted by the Pharmacy Claims Administrator to provide prescription drug services to Covered Persons.

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 Benefits (Out-of-Network Services)
Covered Services which are provided by an Out-of-Network Provider and which are covered by the Plan at a level generally lower than covered services provided by an In-Network Provider (PPO) as shown in the Schedule of Benefits.

Out-of-Network Co-Insurance
The percent (for example: 30%), you pay of the Allowable Amount for Covered Services to Out-of-Network Providers. Out-of-Network Co-Insurance usually costs you more than In-Network Co-Insurance.

Out-of-Network Dentist
A Dentist who has not entered into an agreement to be a part of the Plan's Participating Dentist Network.

Out-of-Network Pharmacy
A Pharmacy that has not contracted with the Plan. Charges for Out-of-Network Pharmacies are **not** covered.

Out-of-Network Provider
A Provider that has not entered into an agreement with the Medical Claims Administrator to be a part of its BluePreferred PPO, BlueChoice PPO or BlueCard PPO Provider Networks.

Outpatient
A Covered Person who receives services or supplies while not an Inpatient.

Over-the-Counter (OTC) Drugs
A medication or product that can be purchased without a prescription. Some OTC medications are covered under this Plan, but do require a prescription in order to be covered. Refer to the "Schedule of Prescription Drug Copays" for a list of covered OTC medications.

Participating Dentist

A Dentist who has entered into an agreement with the Plan to bill the Plan directly for Covered Services, and to accept the Plan's Allowable Charge as payment for such Covered Services. Participating Dentists include the national network of Participating Dentists who have entered into an agreement with a BlueCross and BlueShield Plan or Health Care Service Corporation to be a part of the BlueCare Dental Network of America (DNoA).

Participating Governmental Agency

An Employer which has entered into the Inter−Local Governmental Agreement and has elected to participate in the Plan.

Participating Pharmacy

A Pharmacy that has entered into a Participating Pharmacy Agreement with the Prescription Drug Claims Administrator.

Pharmacy

A person, firm or entity duly authorized by law to dispense prescription drugs.

Photochromic Lens

These lenses darken in the sun and lighten inside. UV protection is built in, and they may be made of either glass or plastic. Also known as Transitional lenses.

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.

Physician Services

Health care services that a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

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

This refers to The Oklahoma Public Employees Health and Welfare Plan, which is the program established and maintained for the purpose of providing for its Covered Persons (through the purchase of insurance or otherwise) medical, surgical, prescription drug, dental, vision, life or other Benefits in the event of Illness, Accident, Injury, Disability, death, or the like, all as defined and governed by the provisions of Title 51 of the Oklahoma statutes.

Plan Administrator

The person or entity designated by the Trustees and who has the discretion and authority to control and manage the operation of the Plan.

Plan Year
The period of twelve (12) consecutive months beginning the first day of July and ending the last day of the following June.

PPO Provider
This means Preferred Provider Organization, which is an In-Network Provider.

Polycarbonate Lens
A lens material that is thinner, lighter and more impact resistant than standard plastic. They are the standard for children's eyewear.

Preauthorization
Authorization from the Claims Administrator before the services are rendered that, based upon the information presented by the Covered Person or his/her Provider at the time Preauthorization is requested, the proposed treatment meets the Claims Administrator's guidelines for Medical Necessity.

Preauthorization does not guarantee that the care and services a Covered Person receives are eligible for Benefits under the Plan. At the time the Covered Person's claims are submitted, they will be reviewed in accordance with the terms of the Plan.

Preferred Provider
A Provider who has a contract with the Plan to provide services to you at a discount.

Prescription Drug Coverage
Part of the Plan that helps pay for Prescription Drugs and medications.

Prescription Drugs
Drugs and medications that by law require a prescription.

Progressive Lens
Bifocal or Trifocal (multi-focal) lenses with no visible lines where the lens gradually changes from distance to near. The viewing zones gradually blend into each other.

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

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

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

Reconstructive Surgery

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents Injuries or medical conditions.

Registered Nurse (RN)

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

Rehabilitation Services

Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Renewal Period

The period of time between April 1st and May 31st of each year when eligible Employees can Enroll in, make changes to or cancel their coverage or their Dependents' coverage. Any changes made during this period will be effective on the first day of the new Plan Year, July 1st.

Residential Treatment Center

A state licensed and/or state certified facility that provides a 24−hour level of residential care to patients with long−term or severe Mental Illnesses and/or substance abuse disorders. The care is medically monitored, with 24−hour Physician availability and 24−hour onsite nursing services.

Routine Nursery Care

Ordinary Hospital nursery care of the newborn Covered Person.

Section 125 Cafeteria Plan – Premium-Only Plan

A Section 125 Cafeteria Plan - Premium-Only Plan (POP) allows employees to pay their health insurance premiums on a pre-tax basis instead of after-tax.

Single Vision Lens

A type of spectacle or contact lens that corrects one vision problem, like near or farsightedness

Skilled Nursing Facility

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

- Custodial Care, ambulatory, or part−time care; or
- Treatment for Mental Illness, alcoholism, or pulmonary tuberculosis.

Special Enrollment Period

This is a special, limited period during which individuals who previously declined coverage are allowed to Enroll without having to wait until the next Renewal Period. A Special Enrollment Period can occur if a person with other health coverage loses that coverage or if a person becomes a Dependent through marriage, birth, adoption or Placement for Adoption.

Specialist

A Physician specialist who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a Provider who has more training in a specific area of health care.

Specialty Medications

Specialty medications are high-cost oral, injectable, infused, or inhaled medications that are either self-administered or administered by a healthcare Provider, and used or obtained in either an Outpatient or home setting.

Statement of Health

A document required (in certain circumstances) to be completed by an Employee and/or Spouse and Dependents in order to apply for Additional Life Insurance. The document asks specific questions about an individuals' overall health and is used by the Plan's Life Insurance vendor to determine the insurability of an individual. For more information, see the "**Additional Life Insurance**" section of this Benefit Book.

Surgery

- The performance of generally accepted operative and other invasive procedures;

- The correction of fractures and dislocations;

- Usual and related preoperative and postoperative care.

Temporomandibular Joint Dysfunction/Syndrome (TMJ)

The treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the Temporomandibular Joint. This is not a covered service under the Plan.

Therapy Service

The following services and supplies ordered by a Physician when used to treat and promote your recovery from an Illness or Injury:

- **Radiation Therapy** — the treatment of disease by x−ray, radium, or radioactive isotopes.

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

- **Respiratory Therapy** — introduction of dry or moist gases into the lungs for treatment purposes.

- **Dialysis Treatment** — the treatment of an acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body to include hemodialysis or peritoneal dialysis.

- **Physical Therapy** — the treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio−mechanical and neuro−physiological principles, and devices to relieve pain, restore maximum function, and prevent disability following disease, Injury, or loss of body part.

- **Occupational Therapy** — treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role.

- **Speech Therapy** — treatment for the correction of a speech impairment resulting from disease, Surgery, Injury, congenital and developmental anomalies, or previous therapeutic processes.

Tint (Tinted Lenses)

A lens option where the lenses are either all one color (solid tint), or lenses that are dark at the top and light at the bottom (gradient tint).

Trust

The Trust created between the Inter−Local Governmental Agreement and the Trustees which establishes the fund to and from which moneys are allocated for the payment of Covered Persons' Benefits and the expenses of administering the Plan.

Trust Agreement

The agreement that creates the Trust for the purpose of holding assets of the Plan.

Trustee

The natural persons designated by the Inter−Local Government Agreement and their successors appointed according to the Trust Agreement, having the exclusive authority and discretion to manage and control the assets of the Plan.

Urgent Care

Care for an Illness, Injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Waiting Period

This is the period of time that must pass before an Eligible Employee or Eligible Dependent is Eligible to Enroll under the Plan. Check with your Employer to find out what your Waiting Period is, if any. If an Eligible Employee or Dependent Enrolls during a Special Enrollment period, any period before such late or special enrollment is not a Waiting Period.

Regarding Orthodontic Treatment for covered dependent children, the term Waiting Period refers to the time that must pass, after enrollment begins, before the Plan will pay any Orthodontic benefits.

WellVision Exam®

A WellVision Exam is something only VSP can offer. VSP doctors do much more than a quick check of your eyes. They'll carefully look for eye problems and other health conditions.

Examples of How Medical Claims are Paid

These examples show how the Plan might cover medical care in certain situations. Use these examples to see, in general, how much protection you might get from the Plan.

This is not a cost estimator.
Don't use these examples to estimate your actual costs under this Plan. The actual care you receive will be different from these examples and the cost of that care will also be different.

Example # 1: Sharon has Employee-only coverage and her first claim of the Plan Year is for surgery through an In-Network Provider. Following are the details of the claim:

- **Allowable Charges**: **$11,500 (billed charges minus PPO discount)**
- **Plan Pays:** **$8,400**
- **Sharon Pays:** **$3,100**

Billed Charges:	**$19,500**	
In-Network Discount:	**$8,000***	(amount to be written-off by In-Network Provider)
Total Allowable Charges:	**$11,500**	($19,500 billed charges minus $8,000 PPO discount)
Amount applied to Deductible:	**$1,000**	(maximum In-Network Deductible per Plan Year)
Amount subject to Co-Insurance:	**$10,500**	($11,500 Allowable Charges minus $1,000 Deductible)
Sharon's 20% Co-Insurance:	**$2,100**	(20% of $10,500)
Sharon's out-of-pocket amount:	**$3,100**	($1,000 Deductible + $2,100 Co-Insurance)

*** Discounts will vary by each individual In-Network Provider who contracts with BlueCross BlueShield, and may even vary for the same procedures.**

Example # 2: Sharon, from Example #1 above, now has a second claim during the same Plan Year. She has already met her **$1,000** Deductible for the Plan Year and she has met **$2,100** of Co-Insurance, for a total of $3,100 towards her Maximum Out-of-Pocket amount of $5,000. She is having another surgery through an In-Network Provider. Following are the details of the claim:

- **Allowable Charges**: **$12,250 (billed charges minus PPO discount)**
- **Plan Pays:** **$10,350**
- **Sharon Pays:** **$ 1,900**

Billed Charges:	**$25,000**	
In-Network Discount:	**$12,750**	(amount to be written-off by In-Network Provider)
Total Allowable Charges:	**$12,250**	($25,000 billed charges minus $12,750 PPO discount)
Amount applied to Deductible:	**$0**	(Deductible already met this Plan Year)
Amount subject to Co-Insurance:	**$12,250**	(Allowable Charges)
Sharon's 20% Co-Insurance:	**$2,450**	(20% of $12,250)

But Wait! - the $2,450 Co-insurance would put her over the $5,000 Maximum Out-of-Pocket Limit for the Plan Year because she already met $3,100 of her Maximum Out-of-Pocket Limit in example #1. Therefore, her Co-insurance for this claim will only be **$1,900** ($5,000 Out-of-Pocket Limit minus $3,100 already met) and the Plan will pay the rest of the Allowable Charges. Since Sharon has now met her full In-Network Maximum Out-of-Pocket Limit for the Plan Year, the Plan will now pay 100% of Sharon's eligible claims from an In-Network Provider for the remainder of the Plan Year.

Sharon's out-of-pocket amount: **$1,900** (The remainder of her Co-Insurance for the Plan Year)

Example # 3: Mary has Employee-only coverage under the Plan. She has not met any of her Deductible or Co-Insurance this Plan Year. She is seeing her In-Network doctor today for her annual Well Woman Exam and cervical screening. Here is how her claim will look:

- **Allowable Charges**: **$150 (billed charges minus PPO discount)**
- **Plan Pays:** **$150**
- **Mary Pays:** **$0**

Billed Charges:	**$250**	
In-Network Discount:	**$100**	(amount to be written-off by an In-Network Provider)
Total Allowable Charges:	**$150**	($250 billed charges minus $100 PPO discount)
Amount applied to Deductible:	**$0**	(Deductible does not apply to In-Network Preventive Services)
Amount subject to Co-Insurance:	**$0**	(Co-Insurance does not apply to In-Network Preventive Services)
Mary's out-of-pocket amount:	**$0**	(Plan pays 100% of In-Network Preventive Services)

Example # 4: Thomas has Employee-only coverage through the Plan. He had a medical procedure performed by an Out-of-Network Provider. Since Thomas went Out-of-Network for his procedure, the doctor is allowed to balance bill him. This means that the discounted (Non-Allowed) amount that would have been written-off by an In-Network Provider can now be charged back to him. Thomas has not yet met any of his Out-of-Network Deductible for this Plan Year. The Deductible for Out-of-Network claims is **$2,000** and the Co-Insurance for Out-of-Network claims is **30**%. The Maximum Out-of-Network Out-of-Pocket Limit is $10,000 per Plan Year. Here are the details of the claim:

- **Billed Charges**: **$4,200**
- **Plan Pays:** **$ 280**
- **Thomas Pays:** **$3,920**

Billed Charges:	**$4,200**	
Non-Allowed Charges:	**$1,800**	(amount not covered by the Plan; can be Balance Billed)
Total Allowable Charges:	**$2,400**	($4,200 billed charges minus $1,800 non-allowed charges)
Amount applied to Deductible:	**$2,000**	(Out-of-Network Deductible is $2,000)
Amount subject to Co-Insurance:	**$ 400**	($2,400 Allowable Charges minus $2,000 Deductible)
Thomas' 30% Co-insurance:	**$ 120**	(30% of $400)
Balance Billing:	**$1,800**	(This is the original non-allowed amount that the Out-of-Network Provider can Balance Bill Thomas)
Thomas' out-of-pocket amount:	**$3,920**	($2,000 Deductible + $120 Co-Insurance + $1,800 Balance Billing)

Example # 5: This example shows what Thomas, in example #4, would have paid if he had received services from an In-Network Provider for his medical procedure:

- **Allowable Charges**: **$2,400 (billed charges minus PPO discount)**
- **Plan Pays:** **$1,120**
- **Thomas Pays:** **$1,280**

Billed Charges:	**$4,200**	
In-Network Discount:	**$1,800**	(amount to be written-off by the In-Network Provider)
Total Allowed Charges:	**$2,400**	($4,200 billed charges minus $1,800 PPO discount)
Amount applied to Deductible:	**$1,000**	(maximum In-Network Deductible per Plan Year)
Amount subject to Co-Insurance:	**$1,400**	($2,400 Allowed Charges minus $1,000 Deductible)
Thomas' 20% Co-Insurance:	**$ 280**	(20% of $1,400)
Thomas' out-of-pocket amount:	**$1,280**	($1,000 Deductible + $280 Co-Insurance)

[END]