Your Health Care Benefit Program

For Employees of
The Hawthorn Group

Effective January 1, 2013

Administered by:

BlueCross BlueShield of Oklahoma

Experience. Wellness. Everywhere.℠

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Plan Summary

The Hawthorn Group (called the ***Employer***) has established and maintains a self–insured Plan of Comprehensive Health Care Benefits (called the ***Plan***) for its eligible Employees and other persons as designated in its personnel policy.

The Plan is operated under an Administrative Services Agreement between the Employer and Blue Cross and Blue Shield of Oklahoma, a division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association, (called **BCBSOK** or the ***Claims Administrator***).

Under this Agreement, BCBSOK pays Benefits on behalf of the Employer in accordance with the terms of the Plan and performs certain other services on behalf of the Employer. The Employer reserves the right to amend or cancel any or all provisions of the Plan at any time as it relates to any Covered Person.

The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

This benefit booklet replaces any and all summaries, certificates or benefit booklets previously issued for the Employees under the Plan. It describes the Plan in effect as of January 1, 2013, for all Covered Persons (called "you" or "your").

The Employer, as Plan Administrator, has the right to terminate, amend or change the Plan at any time without the consent of Covered Persons.

Important Information

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

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

The BlueChoice PPO Provider Network

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

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

How Your BlueChoice PPO Coverage Works

Your BlueChoice PPO coverage is designed to give 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 Covered Persons who choose to use a BlueChoice PPO Provider.

In contrast, when care is received from a Physician who is not a member of the BlueChoice PPO Provider Network, a *higher* Coinsurance and Out–of–Pocket Limit will apply to most Covered Services. However, if a Covered Person receives services from an Out–of–Network Provider in a BlueChoice PPO or BlueCard PPO Hospital for anesthesiology, radiology, laboratory or pathology services, Benefits will be provided as if such services were received under the same conditions from a PPO Provider.

If there is not a BlueChoice PPO or BlueCard PPO Provider within a 25 mile radius of where a Covered Person resides, Benefits will always be paid at a higher PPO Provider level.

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

Selecting a Provider

A listing of network Providers are available on–line through the Blue Cross and Blue Shield of Oklahoma Web site at www.bcbsok.com. **Although every effort is made to provide an accurate listing of network Providers, additions and deletions will occur.** Therefore, you should check with Blue Cross and Blue Shield of Oklahoma or the Provider to be sure of the Provider's BlueChoice PPO status.

If you do not have Internet access, you may obtain Provider information, including a listing of Providers, by contacting a Customer Service Representative at 1−800−672−2567.

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

THE BLUECARD PPO PROGRAM

The BlueCard Program allows you to use a Blue Cross and Blue Shield PPO Physician or Hospital outside the state of Oklahoma and to receive the advantages of PPO benefits and savings.

- **Finding a PPO Physician or Hospital**

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

- **Available Care Coast to Coast**

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

- **Remember to Always Carry the BlueCard**

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

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

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

How The BlueCard PPO Program Works

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

Your Prescription Drug Program

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

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

How Your Prescription Drug Program Works

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

REMEMBER — Using Participating Pharmacies can save you time and money. If you have any questions about your Prescription Drug coverage, please call a Customer Service Representative at 1–800–672–2567.

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

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

Mail-Order Pharmacy Program

Your coverage also provides Benefits for mail order Presciption Drugs. Mail order Prescription Drugs are available for maintenance medications (those that are taken for a long period of time, such as drugs prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, the mail order Pharmacy is able to offer Covered Persons significant savings on their prescriptions. See the "Prescription Drug Benefits" section for the provisions applicable to mail order prescriptions.

Your Participating Dental Network

Blue Cross and Blue Shield 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 your shared payment amount. **If your Participating Dentist charges more than the Claims Administrator'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 one of the Claims Administrator's Customer Service Representatives at 1−888−381−9727. You may also look up in−state (Oklahoma) and out−of−state Dentists on the "Provider Directory" section of the Blue Cross and Blue Shield of Oklahoma Web site at www.bcbsok.com.

Medical Necessity Limitation

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

This program provides Benefits for Covered Services that are Medically Necessary. **"Medical Necessary" is defined as health care services that a Hospital, Physician, or other Provider, exercising prudent clinical judgement, would provide to a patient for the purpose of preventing, evaluation, diagnosing or treating an illness, injury, disease or its symptoms, and that are:**

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

Preauthorization

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

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."**

If you utilize a network Provider for Covered Services, that Provider may request Preauthorization for the services. However, it is your responsibility to assure that the services are Preauthorized before you receive care.

- **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, 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/Expedited Clinical Claims or Emergency Care, the Covered Person should refer to the Preauthorization/Precertification procedures outlined below in this "Preauthorization/Precertification" section.

- **Preauthorization Process for Psychiatric Care Services**

  All **Inpatient** services related to treatment of Mental Illness (including Severe Mental Illness), drug addiction, substance abuse, or alcoholism must be Preauthorized by the Claims Administrator. Preauthorization is also required for the following **Outpatient** Mental Health and Substance Abuse Services:

  — Psychological testing;

  — Neuropsychological testing;

  — Electroconvulsive therapy;

  — Intensive Outpatient Treatment.

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

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

- **Preauthorization Process for Other Outpatient Services**

  In addition to the Preauthorization requirements outlined above for Inpatient facility services and Inpatient and Outpatient treatment of Mental Illness or substance abuse, the Plan also requires Preauthorization for other Outpatient services such as Home Health Care and Hospice Services. If you fail to request Preauthorization

approval, or to abide by the Claims Administrator's determination regarding these services, your Benefits will be *denied* or *reduced*. The ***"Covered Comprehensive Health Care Services"*** section of the Plan details the services which are subject to Preauthorization, along with any Benefit reductions which may apply if you fail to comply with those Preauthorization requirements.

- **Preauthorization 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, the Claims Administrator will notify you in writing, prior to the expiration of the original 15–day period, that the extension is necessary, along with an explanation of the circumstances requiring the extension of time and the date by which the Claims Administrator expects to make the determination.

  If an extension of time is necessary due to their 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 entitled, "***Complaint/Appeal Procedure***."

- **Preauthorization Requests Involving Urgent Care**

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

  — could seriously jeopardize the life or health of the 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," the Claims Administrator will respond to you no later than 72 hours after receipt of the request, unless you fail to provide sufficient information, in which case, you will be notified of the missing information within 24 hours and will have no less than 48 hours to provide the information. A Benefit determination will be made as soon as possible (taking into account medical exigencies) but no later than 72 hours after the initial request, or within 48 hours after the missing information is received (if the initial request is incomplete).

- **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 in the Plan *if you or your Provider notifies the Claims Administrator within two working days following your emergency admission.*

- **Failure to Preauthorize**

  If you do not call for Preauthorization for Inpatient services, the admission will be subject to a $500 reduction in Benefits, if upon receipt of the claim, it is determined that the services were not Medically Necessary. 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 the Outpatient Psychiatric Care Services specified above:

— 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 this 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).

Concurrent Review

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

What To Do In An Emergency

In the case of an emergency, when you get immediate medical assistance from a Hospital, Physician or other Provider that best meets the needs of your emergency, those Covered Services will receive the maximum allowable Benefits based upon the Allowable Charge for those services. If you use an Out–of–Network Provider for your Emergency Care, you will not be subject to the higher Coinsurance amount nor the Out–of–Network Hospital Deductible normally associated with your use of an Out–of–Network Provider.

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

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

Allowable Charge

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 BlueChoice PPO Providers in Oklahoma and BlueCard PPO Providers whenever you are out of state. Using these Providers offers you the following advantages:

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

- 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 Copayment, Deductible and/or Coinsurance amounts which may be applicable to your Covered Services. They will then determine your Benefits under the Plan, and direct any payment to your network Provider.

REMEMBER ...

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

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 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 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 Copayment, Deductible and/or Coinsurance 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 Plan 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 Copayment or Coinsurance 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 Blue Cross and Blue Shield of Oklahoma or with the local Blue Cross and Blue Shield Plan, the "Allowable Charge" will be determined by the Blue Cross and Blue Shield Plan (Host Plan) servicing the area. This Allowable Charge will be the amount the Host Plan uses for their own local members that obtain services from local Non–Contracting Providers.

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

- Charges for any services which are not covered under your Plan.
- Any Deductible or Coinsurance amounts that are applicable to your coverage *(including the higher Coinsurance amounts which apply to Out–of–Network Provider services).*
- The difference, if any, between your Provider's billed charges and the Allowable Charge determined by the Host Plan.

To take full advantage of the negotiated pricing arrangements in effect between the Claims Administrator and their network of Participating Dentists, it is imperative that you use Participating Dentists whenever possible. Using these Providers offers you the following advantages:

- Participating Dentists have agreed to hold the line on dental care costs by providing special prices for Covered Persons. These Providers will accept this negotiated price (called the **"Allowable Charge"**) as payment for Covered Services. This means that, if a Participating Dentist bills you more than the Allowable Charge for Covered Services, ***you are not responsible for the difference.***
- The Claims Administrator will calculate your Benefits based on this "Allowable Charge". The Claims Administrator will deduct any charges for services which aren't eligible under your coverage, then subtract your Coinsurance amounts which may be applicable to your Covered Dental Services, as set forth in the ***"Schedule of Benefits Covered Dental Services"***. They will then determine your Benefits under the Plan, and direct any payment to your Participating Dentist.
- If you use an Out–of–Network Dentist, you will be responsible for the following:

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

  — Any Coinsurance amounts that are applicable to your coverage; and

Special Audit Provision

If a Covered Person audits any Physician, Hospital, or other Provider bill and discovers an error which results in savings to the Plan, the Covered Person shall share equally in the savings, not to exceed a maximum payment of $500. Errors already detected and corrected by the Claims Administrator are not included.

Special Notices

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

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

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

Identification Card

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

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

Carry your card at all times. If you lose your card, you can still use your coverage. You can replace your card faster, however, if you know your identification number.

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

Designating an Authorized Representative

The 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.

Questions

Whenever you call the Claims Administrator's offices for assistance, please have your Identification Card with you.

You usually will be able to answer your health care Benefit questions by referring to this benefit booklet. If you need more help, please call a Customer Service Representative at 1–800–672–2567.

Or you can write:

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

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

- the date of service;
- name of Physician or Hospital;

- the kind of service you received; and
- the charges involved.

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

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

Eligibility, Enrollment, Changes & Termination

This section tells:

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

Who Is an Eligible Person

You are an Eligible Person if you are a regular, full–time active Employee who is directly employed in the regular business of and compensated for services by the Employer and regularly working 40 or more hours per week.

The date you become eligible is the day you complete 90 days of continuous employment (your Waiting Period).

If you are an Eligible Person and you apply for Single Coverage or Family Coverage within 31 days of being first eligible (your Initial Enrollment Period), your Effective Date is the first day of the month coinciding with or next following the date you complete 90 days of continuous, full–time employment.

If an Employee who was previously covered by this Plan is re–hired within thirty (30) days after termination of employment due to any termination including lay–off, approved leave of absence or work related Injury, coverage will be reinstated back to the original Effective Date of the policy and the Waiting Period will be waived.

If an Employee who was previously covered by this Plan is re–hired more than thirty (30) days after termination of employment due to lay–off, approved leave of absence or work related Injury, the Employee will be considered a new Employee and will be subject to the Waiting Period provisions of this Plan.

Who Is an Eligible Dependent

An Eligible Dependent is defined as:

- your legal spouse (must have a valid marriage license that is recognized by the state of Oklahoma – excludes common–law).
- your Dependent child. "Dependent child", means a natural child, a stepchild, an adopted child or child Placed for Adoption (including a child for whom you our 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. A child not listed above who is legally and financially dependent upon you or your spouse is also considered a Dependent child, provided proof of dependency is provided with the child's application.

  A Dependent child who is medically certified as disabled and dependent upon you or your spouse is eligible to continue coverage beyond the limiting age, provided the disability began before the child attained the age of 26.

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

No Dependent is eligible for coverage unless the Employee is covered.

How to Enroll

To Enroll in the Plan, you must complete an application form provided by the Employer, including all information needed to determine eligibility. If you do not want to be covered, you must sign a waiver of benefits form.

Initial Enrollment Period

- **Initial Enrollment**

  If you are an Eligible Person and your application for coverage is received during the Initial Enrollment Period, the Effective Date for you and your Eligible Dependents (if applicable) is the first day of the month following 90 days of full time employment.

- **Initial Enrollment After the Plan Effective Date**

  If you become an Eligible Person after the Plan Effective Date and your application is received by the Plan within 31 days of being first eligible, the Effective Date for you and your Eligible Dependents (if applicable) will be assigned by the Plan, according to the provisions of this Plan.

- **Initial Enrollment for Dependents**

  If you enrolled in Employee–only coverage you can apply to add Dependents to your coverage if your application is received within 31 days after you acquire an Eligible Dependent. The Effective Date for the Eligible Dependent will be the date the Dependent was acquired. You must notify the Employer when a new Dependent is acquired.

  Coverage will not become effective for the Dependents of an Employee unless the Employee is covered. Under no circumstances will coverage for a Dependent become effective prior to coverage for the Employee becoming effective.

When Coverage Begins

If you are an Eligible Person and you apply for Single Coverage or Family Coverage within 31 days of being first eligible (your Initial Enrollment Period), your Effective Date is the first day of the month coinciding with or next following the date you complete 90 days of continuous, full–time active employment.

How To Add Dependents

You can add Eligible Dependents to your coverage if BCBSOK receives your application within 31 days after you acquire an Eligible Dependent. The Effective Date for the Eligible Dependent will be the date the Eligible Dependent was acquired.

An adopted child or child Placed for Adoption may be added to your coverage, provided your application is received by BCBSOK within 31 days following the date the child is placed in your custody. The Effective Date for the child will be the date you assumed the physical custody of the adopted child and the financial responsibility for the support and care of the adopted child. A copy of the court order or adoption papers must be submitted to BCBSOK with the application form.

An Employee may not be covered under this Plan as both an Employee and a Dependent.

Qualified Court Orders for Medical Coverage for Dependent Children

The Plan will honor certain qualified medical child support orders (QMCSO). To be qualified, a court of competent jurisdiction must enter an order for child support requiring coverage under the 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 Plan to which the order applies.

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

The Plan has to follow certain procedures with respect to qualified medical child support orders. If such an order is issued concerning your child, you should contact a Customer Service Representative by calling the telephone number shown on your Identification Card.

Special Enrollment Periods

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

A Preexisting Condition Exclusion cannot apply to Covered Persons under age 19.

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

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

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

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

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

    ○ the Plan required such a statement when you declined enrollment; and

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

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

- you and/or your Dependent had COBRA Continuation Coverage under another plan and COBRA Continuation Coverage under that other plan has since been exhausted; or
- if the other coverage that applied to you and/or your Dependent when enrollment was declined was not under a COBRA continuation provision, either the other coverage has been terminated as a result of loss of eligibility for the coverage or employer contributions towards the other coverage have been terminated.

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

— Your application for special enrollment must be received by the Plan within 31 days following the loss of other coverage. Coverage under special enrollment will be effective no later than the first day of the month after the Plan receives your application for enrollment for yourself or on behalf of your Dependent(s).

- **Special Enrollment For New Dependents**

A Special Enrollment Period occurs if a person has a new Dependent by birth, marriage, adoption, or Placement for Adoption. Your application must be received within 31 days following the birth, marriage, adoption, or Placement for Adoption. To Enroll an adopted child, a copy of the court order or adoption papers must accompany the application or change form. Special enrollment rules provide that:

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

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

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

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

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

— Coverage with respect to a marriage is effective on the marriage date.

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

- **Special Enrollment for Court–Ordered Dependent Coverage**

An Eligible Dependent is not considered a Late Enrollee if the Employee's application to add the Dependent is received within 31 days after issuance of a court order requiring coverage be provided for a spouse or minor or

Dependent child under the Employee's coverage. The Effective Date will be determined by the Plan Administrator in accordance with the provisions of the court order.

- **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 contribution 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 Group Health Plan experience either of the following qualifying events:

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

  — The Employee or Dependent becomes eligible for a Group Health Plan contribution assistance subsidy under Medicaid or CHIP.

  An Employee must request this special enrollment into the Group Health Plan within 60 days of the loss of Medicaid or CHIP coverage, and within 60 days of the Employee or Dependent becoming eligible for a Group Health Plan contribution 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.

Employees and/or Dependents who are not enrolled during the Initial Enrollment Period or a Special Enrollment Period must wait until the next annual Open Enrollment Period to Enroll for coverage. The annual Open Enrollment Period is designated by the Employer each year. It is held before the start of each Plan Year. During this period, all Eligible Employees and Eligible Dependents can Enroll for coverage.

Open Enrollment Period

The Plan provides an Open Enrollment Period which is held during the month of November each year. During this period, an eligible Employee and/or eligible Dependent who did not Enroll for coverage during their Initial Enrollment Period or during a Special Enrollment Period may Enroll for coverage under the Plan. If your application for enrollment is received during the Open Enrollment Period, the Effective Date for the Employee and/or Dependent will be January 1 and remain in effect until January 1 unless there is a change in family status (Qualifying Event) during the year (birth, death, marriage, divorce, adoption, loss of coverage or change in spouse's employment) of the following year. If there is a change in status you must notify the Employer within 31 days of the change. Persons who Enroll during the Open Enrollment Period will be considered Late Enrollees and will be subject to an 18–month Preexisting Condition Exclusion period.

A Preexisting Condition Exclusion cannot apply to Covered Persons under age 19.

Leave of Absence

For a leave of absence covered under the Family and Medical Leave Act (FMLA), Eligible Persons will be granted, upon request, up to 12 weeks of unpaid leave for certain family and medical reasons during a 12 month period of time. Eligible Persons shall provide a minimum of 30 days advance notice when the leave is foreseeable. In order to continue coverage under this Plan, you must make arrangements with the personnel department to continue payment of contributions during the leave. If you do not return to work at the end of the 12 week period, your employment will be deemed to have terminated for purposes of COBRA.

Deleting a Dependent

You can change your coverage to delete Dependents during Open Enrollment or due to a Qualifying Event. The change will be effective at the end of the coverage period during which your contributions have been paid.

In the case of divorce, the change will be effective the date the divorce is granted.

If You Turn 65 and Continue Working Full-Time

If you are age 65 or older and are still an active Employee, you are eligible to continue the Plan's level of Benefits. You are also eligible for Medicare benefits on the first day of the month you become 65.

Be sure to apply for both Part A and Part B of Medicare at least three months before your 65th birthday.

COBRA Continuation Coverage

- **Eligibility for Continuation Coverage**

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

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

  — your divorce or legal separation; or

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

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

- **Election of Continuation Coverage**

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

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

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

- **COBRA Continuation Coverage Period**

  You and/or your Eligible Dependents are eligible for coverage to continue under the Plan for a period not to exceed:

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

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

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

    ○ the ineligibility of a Dependent child;

  provided the contributions are paid for the coverage as required.

- **Disability Extension**

  — COBRA Continuation Coverage may be extended from 18 months to 29 months for you or an Eligible Dependent who is determined by the Social Security Administration to have been disabled on the date of a

Qualifying Event, or within the first 60 days of COBRA Continuation Coverage. This 11−month disability extension is also available to nondisabled family members who are entitled to COBRA Continuation Coverage.

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

- **Multiple Qualifying Events**

  In the event an Eligible Dependent experiences a second Qualifying Event after onset of COBRA Continuation Coverage resulting from your termination or reduction in work hours, the maximum period of coverage is 36 months from the date of a loss in coverage resulting from the first Qualifying Event. This extension is available to the Eligible Dependent only.

- **Special TAA/ATAA Election Period**

  An Employee who loses his/her job due to a trade−related reason may be entitled to a second 60−day COBRA election period if the Employee did not elect COBRA Continuation Coverage when initially eligible to do so. In order to qualify for this election period, the U. S. Department of Labor (or a state labor agency) must issue a certification showing that the job loss was due to trade−related reasons and that the employee is entitled to "trade adjustment assistance" (TAA) or "alternate trade adjustment assistance" (ATAA). The special 60−day election period begins on the first day of the month in which the Employee becomes eligible for trade adjustment assistance, as determined by the Department of Labor or state labor agency. The Employee is not eligible for the special election period if the TAA/ATAA eligibility determination is made more than six months after termination of employment.

Uniformed Services Employment and Reemployment Rights Act (USERRA) of 1994

The Plan shall fully comply with USERRA. If any provision of this Plan is found to be in conflict with USERRA, the conflicting provision shall be reformed, to the full extent practicable, to conform to the requirements of USERRA and any provision which is still in conflict will be void and of no further force or effect. All other Benefits and exclusions of the Plan will remain effective to the extent that there is no conflict with this Act.

When Coverage Under This Plan Ends

Coverage will stop on the date in which an individual ceases to meet the definition of an Eligible Person or Eligible Dependent.

A Covered Person's COBRA Continuation Coverage, when applicable, will cease 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 Continuation Coverage period, whichever is applicable;
- the first day of the month that begins more than 30 days after the date of the Social Security Administration's final determination that the 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 date on which coverage stops because of a Covered Person's failure to pay any contribution required for the COBRA Continuation Coverage;
- the date on which the Covered Person first becomes (after the date of the election) covered under any other Group Health Plan which does not contain any exclusion or limitation with respect to a Preexisting Condition

applicable to the Covered Person (or the date the Covered Person has satisfied the Preexisting Condition Exclusion period under that plan); or

- the date on which the Covered Person becomes (after the date of the election) entitled to benefits under Medicare.

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

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

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

Certificates of Coverage

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

- **Qualified Beneficiaries Upon a Qualifying Event**

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

- **Other Individuals When Coverage Ceases**

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

- **Qualified Beneficiaries When COBRA Ceases**

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

- **Any Individual Upon Request**

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

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

Schedule of Benefits
Comprehensive Health Care Services
PPO PLAN

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

BENEFIT PERIOD	Calendar Year.
OFFICE VISIT COPAYMENT	$20 for each visit to a BlueChoiceor BlueCard Physician's office.
SPECIALIST OFFICE VISIT COPAYMENT	$50 for each visit to a BlueChoice or BlueCard Specialist Physician's office. The Copayment applies to the office visit charge only. All other services performed in the office are subject to the Benefit Period Deductible and/or Coinsurance.
RADIOLOGY SERVICES COPAYMENT	$200 per occurence for radiology services of CT scan, Petscan, MRI and MRA. The remaining charges are subject to regular Plan Deductible and Coinsurance. This Copayment does not count towards the Deductible or Out–of–Pocket Limits.
DEDUCTIBLE	
Out–of–Network Hospital Deductible	$250 per Inpatient Hospital Admission. This Deductible applies to all Covered Services Incurred during your admission to a Hospital which is not a BlueChoice or BlueCard Provider.
Out–of–Network Preventive Care Services Deductible	$250 per occurrence. This Deductible applies to all Preventive Care Services rendered Out–of–Network. The Out–of–Network Coinsurance also applies. The Benefit Period Deductible is in addition to the Out–of–Network Hospital Deductible and Out–of–Network Preventive Care Services Deductible described above.
BlueChoice or BlueCard Provider Services Deductible	$1,000 per Benefit Period per Covered Person. This Deductible applies to Covered Services received from a BlueChoice or BlueCard Provider. If the Covered Person has Incurred expenses which were applied toward his or her Out–of–Network Provider Services Deductible during the Benefit Period, those expenses will also count toward satisfaction of his or her Deductible amount for BlueChoice or BlueCard Provider Services.

Out–of–Network Provider Services Deductible	$2,000 per Benefit Period per Covered Person. This Deductible applies whenever the Covered Person receives Covered Services from a Provider who is not a member of the BlueChoice or BlueCard Provider Network. If the Covered Person has Incurred expenses which were applied toward his or her BlueChoice or BlueCard Provider Services Deductible during the Benefit Period, those expenses will also count toward satisfaction of his or her Deductible amount for Out–of–Network Provider Services.
Covered Services ***Not*** Subject to Benefit Period Deductible	The Benefit Period Deductible applies to all Covered Services, except: • Routine Nursery Care. • In–network Preventive Care Services. • Home Health Care. • Hospice Care. • BlueChoice or BlueCard Physician services which are subject to the office visit Copayment.

FAMILY DEDUCTIBLE

BlueChoice or BlueCard Provider Services Deductible	$2,000 per Benefit Period for all covered family members.
Out–of–Network Provider Services Deductible	$4,000 per Benefit Period for all covered family members.
	No family Covered Person will contribute more than the individual Deductible amount. The Family Deductible provisions described above apply only to the Benefit Period Deductible and does not include any other Deductible applicable to your coverage.

OUT-OF-POCKET LIMIT

- **BlueChoice and BlueCard Provider Services —** When you have Incurred $3,000 (in excess of any Copayment and/or Deductible amounts) for Covered Services provided by BlueChoice and BlueCard Providers during a Benefit Period, the amount of Allowable Charges covered by the Plan on your behalf will increase to 100% during the remainder of the Benefit Period for Covered Services you receive from network Providers.
- **Out–of–Network Provider Services** — When you have Incurred $6,000 (in excess of any Copayment and/orDeductible amounts) for Covered Services provided by Out–of–Network Providers during a Benefit Period, the amount of Allowable Charges covered by the Plan on your behalf will increase to 100% during the remainder of the Benefit Period for Out–of–Network Provider services.

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

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

- Preauthorization penalties.
- Deductibles.
- BlueChoice or BlueCard Physician services which are subject to the office visit Copayment.
- Outpatient Prescription Drugs.
- Charges in excess of the Allowable Charge.

FAMILY OUT–OF–POCKET LIMIT

- **BlueChoice and BlueCard Provider Services —** When you and your Dependents have Incurred $6,000 in (excess of any Copayment and/or Deductible amounts for Covered Services provided by BlueChoice and BlueCard Providers during a Benefit Period, the amount of Allowable Charges covered by the Plan on behalf of all covered family members will increase to 100% during the remainder of the Benefit Period for Covered Services you receive from network Providers.
- **Out–of–Network Provider Services** — When you and your Dependents have Incurred $12,000 (in excess of any Deductible amounts) for Covered Services provided by Out–of–Network Providers during a Benefit Period, the amount of Allowable Charges covered by the Plan on behalf of all covered family members will increase to 100% during the remainder of the Benefit Period for Out–of–Network Provider services.

MAXIMUM

Benefit Period	$2,000,000 maximum per Benefit Period per Covered Person for essential health care benefits, as defined by federal law.
Lifetime	Unlimited

BENEFIT PERCENTAGE

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

The Deductible does not apply to in–network Preventive Care and Home Health Services.

COVERED SERVICES (Subject to the *Comprehensive Health Care Services* section which follows)	BENEFIT PERCENTAGE AMOUNT: BlueChoice & BlueCard Provider Services	Out–of–Network Provider Services
PREVENTIVE CARE SERVICES*	100%	60%
HOME HEALTH CARE SERVICES*	100%	60%
THE FOLLOWING BENEFIT PERCENTAGES APPLY TO SERVICES THAT ARE NOT CLASSIFIED AS PREVENTIVE CARE SERVICES OR HOME HEALTH CARE SERVICES, AS DETERMINED BY THE CLAIMS ADMINISTRATOR		
EMERGENCY CARE SERVICES	80%	80%
HOSPITAL SERVICES	80%	60%
SURGICAL/MEDICAL SERVICES		
Physicians' and Specialists' Office Visits	100%**	60%
All Other Covered Surgical/Medical Services	80%	60%
OUTPATIENT THERAPY SERVICES	80%	60%
OUTPATIENT DIAGNOSTIC SERVICES	80%	60%
MATERNITY SERVICES	80%	60%
MASTECTOMY AND RECONSTRUCTIVE SURGICAL SERVICES	80%	60%
MUSCLE MANIPULATIONS AND SPINAL SUBLUXATION SERVICES	50%	50%
HUMAN ORGAN, TISSUE AND BONE MARROW TRANSPLANT SERVICES	80%	60%
AMBULATORY SURGICAL FACILITY SERVICES	80%	60%
AMBULANCE SERVICES	80%	60%
PSYCHIATRIC CARE SERVICES	80%	60%
REHABILITATION CARE	80%	60%

**Deductible applies to Out–of–Network services.*

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

COVERED SERVICES (Subject to the *Comprehensive Health Care Services* section which follows)	BENEFIT PERCENTAGE AMOUNT: BlueChoice & BlueCard Provider Services	Out–of–Network Provider Services
SKILLED NURSING FACILITY SERVICES	80%	60%
HOSPICE SERVICES	100%	60%
TEMPOROMANDIBULAR JOINT SYNDROME/DYSFUNCTION	50%	50%
DENTAL SERVICES FOR EXTRACTION OF WISDOM TEETH AND ACCIDENTAL INJURY	80%	60%
ALL OTHER COVERED SERVICES	80%	60%

Schedule of Benefits
Comprehensive Health Care Services
HDHP PLAN

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

BENEFIT PERIOD	Calendar Year.
DEDUCTIBLE	
	The Benefit Period Deductible is in addition to the Out–of–Network Hospital Deductible, Out–of–Network Preventive Care Deductible described above.
BlueChoice or BlueCard Provider Services Deductible	$2,500 per Benefit Period per Covered Person. This Deductible applies to Covered Services received from a BlueChoice or BlueCard Provider. If the Covered Person has Incurred expenses which were applied toward his or her Out–of–Network Provider Services Deductible during the Benefit Period, those expenses will also count toward satisfaction of his or her Deductible amount for BlueChoice or BlueCard Provider Services.
Out–of–Network Provider Services Deductible	$3,500 per Benefit Period per Covered Person. This Deductible applies whenever the Covered Person receives Covered Services from a Provider who is not a member of the BlueChoice or BlueCard Provider Network. If the Covered Person has Incurred expenses which were applied toward his or her BlueChoice or BlueCard Provider Services Deductible during the Benefit Period, those expenses will also count toward satisfaction of his or her Deductible amount for Out–of–Network Provider Services.
Covered Services ***Not*** Subject to Benefit Period Deductible	The Benefit Period Deductible applies to all Covered Services, except: • Routine Nursery Care. • Home Health Care. • Hospice Care. • Preventive Care Services.

FAMILY DEDUCTIBLE

BlueChoice or BlueCard Provider Services Deductible	$5,000 per Benefit Period for all covered family members.
Out–of–Network Provider Services Deductible	$7,000 per Benefit Period for all covered family members.

No family Covered Person will contribute more than the individual Deductible amount.

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

OUT-OF-POCKET LIMIT

- **BlueChoice and BlueCard Provider Services —** When you have Incurred $2,500 for Covered Services provided by BlueChoice Provider and BlueCard Providers during a Benefit Period, the amount of Allowable Charges covered by the Plan on your behalf will increase to 100% during the remainder of the Benefit Period for Covered Services you receive from network Providers.

- **Out–of–Network Provider Services** — When you have Incurred $5,500 for Covered Services provided by Out–of–Network Providers during a Benefit Period, the amount of Allowable Charges covered by the Plan on your behalf will increase to 100% during the remainder of the Benefit Period for Out–of–Network Provider services.

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

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

- Preauthorization penalties.

- Charges in excess of the Allowable Charge.

FAMILY OUT-OF-POCKET LIMIT

- **BlueChoice and BlueCard Provider Services —** When you and your Dependents have Incurred $5,000 for Covered Services provided by BlueChoice and BlueCard Providers during a Benefit Period, the amount of Allowable Charges covered by the Plan on behalf of all covered family members will increase to 100% during the remainder of the Benefit Period for Covered Services you receive from network Providers.

- **Out–of–Network Provider Services** — When you and your Dependents have Incurred $11,000 for Covered Services provided by Out–of–Network Providers during a Benefit Period, the amount of Allowable Charges covered by the Plan on behalf of all covered family members will increase to 100% during the remainder of the Benefit Period for Out–of–Network Provider services.

MAXIMUM

Benefit Period	$2,000,000 maximum per Benefit Period per Covered Person for essential health care benefits, as defined by federal law.
Lifetime	Unlimited

BENEFIT PERCENTAGE

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

The Deductible does not apply to in–network Preventive Care and Home Health Services.

COVERED SERVICES (Subject to the *Comprehensive Health Care Services* section which follows)	BENEFIT PERCENTAGE AMOUNT: BlueChoice & BlueCard Provider Services	Out–of–Network Provider Services
PREVENTIVE CARE SERVICES	100%	50%
HOME HEALTH CARE SERVICES	100%	50%
THE FOLLOWING BENEFIT PERCENTAGES APPLY TO SERVICES THAT ARE NOT CLASSIFIED AS PREVENTIVE CARE SERVICES OR HOME HEALTH CARE SERVICES, AS DETERMINED BY THE CLAIMS ADMINISTRATOR AND THE DEDUCTIBLE DOES APPLY		
EMERGENCY CARE SERVICES	100%	100%
HOSPITAL SERVICES	100%	50%
SURGICAL/MEDICAL SERVICES	100%	50%
OUTPATIENT THERAPY SERVICES	100%	50%
OUTPATIENT DIAGNOSTIC SERVICES	100%	50%
MATERNITY SERVICES	100%	50%
MASTECTOMY AND RECONSTRUCTIVE SURGICAL SERVICES	100%	50%
MUSCLE MANIPULATIONS AND SPINAL SUBLUXATION SERVICES	100%	50%
HUMAN ORGAN, TISSUE AND BONE MARROW TRANSPLANT SERVICES	100%	50%
AMBULATORY SURGICAL FACILITY SERVICES	100%	50%
AMBULANCE SERVICES	100%	50%
PSYCHIATRIC SERVICES	100%	50%
REHABILITATION SERVICES	100%	50%
SKILLED NURSING FACILITY SERVICES	100%	50%

COVERED SERVICES (Subject to the *Comprehensive Health Care Services* section which follows)	BENEFIT PERCENTAGE AMOUNT: BlueChoice & BlueCard Provider Services	Out–of–Network Provider Services
HOSPICE SERVICES	100%	50%
TEMPOROMANDIBULAR JOINT SYNDROME/DYSFUNCTION	100%	50%
DENTAL SERVICES FOR EXTRACTION OF WISDOM TEETH AND ACCIDENTAL INJURY	100%	50%
OUTPATIENT PRESCRIPTION DRUGS	100%	50%
ALL OTHER COVERED SERVICES	100%	50%

Comprehensive Health Care Services

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

PREVENTIVE CARE SERVICES

Any of the following Covered Services performed by a Provider.

NOTE: Preventive Care Services received from BlueChoice PPO and BlueCard PPO Providers are not subject to Deductible, Copayment, Coinsurance or dollar maximums.

- Evidence–based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF");
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved;
- Evidenced–informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") for infants, children, and adolescents; and
- With respect to women, such additional preventive care and screening, not described in items listed above as provided for in comprehensive guidelines supported by the HRSA.
  - — Breastfeeding Support, Services and Supplies – Benefits will be provided for breastfeeding counseling and support services rendered by a Provider for pregnant and postpartum women. Benefits include the rental (or, at the Plan's option, the purchase if it will be less expensive) of ***manual*** breast pumps, accessories and supplies.
  - — 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 FDA guidelines are modified. Deductible, Coinsurance or Copayment amounts will not apply to FDA−approved contraceptive drugs and devices on the Contraceptive Information list. You may access the Web site at www.bcbsok.com or contact customer service at the toll−free number on your Identification Card.

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

Covered Preventive Care Services received from Out−of−Network Providers and/or Out−of−Network Pharmacies, or other routine Covered Services not provided for under this provision may be subject to Deductible, Copayment, Coinsurance and/or Benefit maximums.

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 Covered Persons may access the Web site at www.bcbsok.com or contact Customer Service at the toll−free number listed on their Identification Card.

Examples of Covered Services included are routine annual physicals, immunizations, well−child care, cancer screening mammograms, bone density test, screening for prostate cancer and colorectal cancer, smoking cessation counseling services, health diet counseling and obesity screening/counseling.

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

Covered Services not included as above may be subject to Coinsurance, Deductible 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,” “Surgical/Medical Services,” and “Diagnostic Services”).

Emergency Care Services

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

- serious jeopardy to the 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,” “Surgical/Medical Services”, and “Ambulance Services.”

HOSPITAL SERVICES

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

- **Bed and Board**

  Bed, board and general nursing service in:

  — A room with two or more beds;

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

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

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

- **Ancillary Services**

  — Operating, delivery and treatment rooms;

  — Prescribed drugs;

  — Whole blood, blood processing and administration;

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

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

  — Oxygen;

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

  — Diagnostic Services;

  — Therapy Services.

- **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.

SURGICAL/MEDICAL SERVICES

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

- **Surgery**

  Payment includes visits before and after Surgery.

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

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

    ○ the primary procedure; plus

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

  — Sterilization, regardless of Medical Necessity.

  — Oral Surgery

    Oral Surgery for surgical removal of complete bony and/or partially impacted teeth.

- **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.

- **Anesthesia**

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

- **Inpatient Medical Services**

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

  — Inpatient Medical Care Visits

**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.*

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

— Intensive Medical Care

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

— Concurrent Care

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

— Consultation

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

— Newborn Well Baby Care

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

- **Outpatient Medical Services**

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

— Emergency Accident Care

Treatment of accidental bodily injuries.

— Emergency Medical Care

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

— Home, Office, and Other Outpatient Visits

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

— Contraceptive Devices

Contraceptive devices which are:

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

— Allergy Diagnosis and Treatment

Evaluation, diagnosis and treatment of allergies.

— Hearing Services

Benefits for hearing test are available for Covered Persons. To be eligible for this Benefit, Covered Persons must be on the Plan for one year.

Benefits for hearing aids are limited to a lifetime maximum of $4,500 per eligible Covered Person.

Outpatient Diagnostic Services

- Radiology, Ultrasound and Nuclear Medicine
- Laboratory and Pathology
- ECG, EEG, and Other Electronic Diagnostic Medical Procedures and Physiological Medical Testing, as determined by the 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 ***Outpatient Prescription Drug Benefits,*** if applicable, under the Plan.

- Respiratory Therapy
- Dialysis Treatment

  Home dialysis and home dialysis training are excluded.

- Speech Therapy
- Physical Therapy

  Benefits for Outpatient Physical Therapy are limited to 25 visits per Benefit Period per Covered Person.

Benefits for Outpatient Occupational Therapy is not a Benefit under this Plan

Maternity Services

- Hospital Services and Surgical/Medical Services from a Provider (not including the services of midwives) to an Employee or the Employee's covered spouse for:
  - — Normal Pregnancy

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

  - — Complications of Pregnancy

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

  - — Interruptions of Pregnancy
    - ○ Miscarriage
    - ○ Therapeutic Abortion

- Covered Maternity Services include the following:
  - A minimum of 48 hours of Inpatient care at a Hospital, or a birthing center licensed as a Hospital, following a vaginal delivery for the mother and newborn infant who are covered under 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 postdischarge; and
    - the availability of postdischarge follow–up to verify the condition of the newborn infant in the first 48 hours after delivery; and
  - The Plan covers one home visit, within 48 hours of discharge, by a licensed health care Provider whose scope of practice includes providing postpartum care. Such visits shall include, at a minimum:
    - physical assessment of the mother and newborn infant;

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

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

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

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).

Mastectomy and Reconstructive Surgical Services

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

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

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

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

Muscle Manipulations and Spinal Subluxation Services

Benefits for muscle manipulation and spinal subluxation as shown in the ***"Schedule of Benefits"*** section and **limited to up to $20 per visit with a maximum of $200 per Benefit Period per Covered Person.**

Human Organ, Tissue and Bone Marrow Transplant Services

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

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

- **DEFINITIONS**

  In addition to the definitions listed under the ***Definitions*** 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 Hospital, Physician, or other Provider for the human organ and tissue transplant procedures set forth below.

  — Musculoskeletal transplants;

  — Parathyroid transplants;

  — Cornea transplants;

  — Heart–valve transplants;

  — Kidney transplants;

  — Heart transplants;

  — Single lung, double lung and heart/lung transplants;

  — Liver transplants;

  — Intestinal transplants;

  — Small bowel/liver or multivisceral (abdominal) transplants;

  — Pancreas transplants;

  — Islet cell transplants; and

  — Bone Marrow Transplants.

- **EXCLUSIONS AND LIMITATIONS APPLICABLE TO ORGAN/TISSUE/BONE MARROW TRANSPLANTS**

  — The transplant must meet the criteria established by the 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 in and 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.

— Benefits are limited to $10,000 combined for transportation, meals and lodging per transplant per Covered Person and $50 per day for lodging for recipient and companion.

- **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 Blue Cross or Blue Shield 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 Blue Cross or Blue Shield coverage or any government program available to the recipient. There are no Covered Services for the non–Covered Person transplant recipient.

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

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

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

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

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

— The Bone Marrow Transplant is available to the 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.

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.

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 one visit or other service per day**;

  — Individual Psychotherapy;

  — Group Psychotherapy;

  — Psychological Testing; and

  — Convulsive Therapy Treatment.

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

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

- Outpatient Psychiatric Care Services

  — Facility and Medical Services

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

Outpatient Convulsive Therapy Treatment is excluded.

- Drug Abuse and Alcoholism

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

Ambulance Services

- Medically Necessary transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured:
  - — From your home to a Hospital, when admitted as an Inpatient;
  - — 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.

Rehabilitation Care

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

Rehabilitation Care is limited to 60 days of Inpatient Care per Benefit Period per Covered Person.

Rehabilitation Care is subject to the Preauthorization guidelines of the Plan (see "*Important Information*"). Failure to comply with these guidelines will result in a $500 reduction in Benefits 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 60 days of Inpatient care per Benefit Period per Covered Person.

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

No Benefits are payable:

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

Home Health Care Services

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 90 days per Benefit Period 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.

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

The Plan does not pay Home Health Care Benefits for:

- Dietician services, except as specified for diabetes self–management training;
- Homemaker services;
- Maintenance therapy;
- Physical Therapy, Speech Therapy, or Occupational Therapy;
- Dialysis Treatment;
- Durable Medical Equipment;
- Purchase or rental of dialysis equipment;
- Food or home–delivered meals;
- 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 (see "*Important Information*"). Failure to comply with these guidelines will result in a $500 reduction in Benefits for Hospice Services, if, upon receipt of a claim, Benefits are payable under the Plan.

Temporomandibular Joint Syndrome/Dysfunction

Surgical treatment of temporomandibular joint (TMJ) dysfunction or any other conditions involving the jaw joint, adjacent muscles or nerves, regardless of cause or diagnosis.

Dental Services for Extraction of Wisdom Teeth and Accidental Injury

Dental Services for extraction of wisdom teeth and treatment of accidental injury to the jaws, sound natural teeth, mouth or face, provided such treatment commences within six months from the date of the injury. Injury caused by chewing or biting an object or substance placed in your mouth is not considered an accidental injury, regardless of whether you knew the object or substance was capable of causing such injury if chewed or bitten.

Diabetes Equipment, Supplies and Self–Management Services

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

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

— Visits when reeducation or refresher training is Medically Necessary.

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", "Outpatient Prescription Drugs" and "Home Health Care Services").

DURABLE MEDICAL EQUIPMENT

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 nonreusable items essential to the effective use of the equipment. Such repair and replacement is not included if the equipment is lost, damaged or destroyed due to improper use or abuse.

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

PROSTHETIC APPLIANCES

Devices, along with pertinent supplies, which replace all or part of an absent body organ and which are Medically Necessary for the alleviation or correction of conditions arising out of bodily injury or illness covered by 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 and at intervals of at least five years.

ORTHOTIC DEVICES

A rigid or semi−rigid supportive device which limits or stops motion of a weak or diseased body part and which is Medically Necessary to restore you to your previous level of daily living activity.

Benefits will be provided for the following orthotic devices:

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

Not covered are:

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

Schedule of Benefits
Outpatient Prescription Drugs
PPO PLAN

This section shows how much the Plan pays for Covered Services described in the ***Outpatient Prescription Drug Benefits*** section that follows**. Please note that services must be Medically Necessary in order to be covered under this program.**

COPAYMENT/COINSURANCE	The Copayment or Coinsurance applicable to each Prescription Order is set forth below:
Retail Pharmacy*	$15.00 Copayment per Prescription Order for Generic Drugs.
	The greater of $35 or 30% Copayment per Prescription Order for Preferred Brand or Formulary Drugs
	The greater of $75 or 30% Copayment per Prescription Order for Non Preferred Brand or Non Formulary Drugs
Specialty Medications	$200 Copayment per Prescription Order for specialty medications. Specialty pharmacy medications are limited to a 30−day supply.
Mail Order Pharmacy*	$25 Copayment per Prescription Order for Generic Drugs.
	$70 Copayment per Prescription Order for Brand Drugs
	$150 Copayment per Prescription Order for Non−Brand Drugs
Specialty Medications	Specialty medications are not available through the Mail Order Pharmacy.
BENEFIT PERCENTAGE AMOUNT	The following shows the amount of Allowable Charges covered by your Plan through Allowable Charges covered by your Plan through payments and/or contractual arrangements with Providers. The amount shown for Non−Participating Pharmacies applies whenever your Prescription Order is filled by a Pharmacy that is not a Participating Pharmacy.

COVERED SERVICES (Subject to the *Outpatient Prescription Drug Benefits* section which follows)	**BENEFIT PERCENTAGE AMOUNT:**	
	Participating Pharmacies	**Non−Participating Pharmacies**
OUTPATIENT PRESCRIPTION DRUGS	100% after the Copayment	75% less the applicable Copayment

* *When a member chooses a brand name prescription when a generic is available, regardless of whether the prescribing doctor or member chooses, the member will be responsible for the applicable Copayment plus the difference in cost between the generic and name brand prescription.*

Outpatient Prescription Drug Benefits

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

Covered Services

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

- Prescription Drugs dispensed for a Covered Person's Outpatient use, when recommended by and while under the care of a Physician or other Provider;
- Injectable insulin and insulin products, but only when dispensed in accordance with a written prescription by a licensed Physician;
- Oral contraceptives, when prescribed by a licensed Physician;
- Prescription Drugs prescribed for treatment of attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD) subject to the Claims Administrator's guidelines for Preauthorization;
- Specialty Pharmacy Drugs (when dispensed by a Pharmacy participating in the Specialty Pharmacy Network, **limited to a 30–day supply per Prescription Order;**
- Vaccinations (when administered by a Participating Retail Pharmacy Vaccination Network Provider). Visit the Claims Administrator's Web site at www.bcbsok.com for a current listing of vaccines available through this program;
- Oral Chemotherapy, when prescribed by a licensed Physician; and
- Self–injectable Prescription Drugs (including Chemotherapy), when dispensed by a Pharmacy. Self–injectable drugs purchased from a Physician and administered in his/her office are not covered. **NOTE:** Many self–injectable drugs are classified as "Specialty Pharmacy Drugs" and must be purchased from a Participating Specialty Pharmacy in order for you to receive the maximum Benefits under this program.

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

Mail–Order Pharmacy Program

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

Only maintenance drugs are available through the Claims Administrator's Mail Order Service.

Payment of Benefits

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

- When Prescription Drugs are dispensed by a Participating Pharmacy the Plan will pay directly to the Pharmacy the Allowable Charge for the drugs, less the applicable Copayment or Coinsurance specified in the ***Schedule of Benefits for Outpatient Prescription Drugs***.

- When Prescription Drugs are dispensed by a Pharmacy which is not a Participating Pharmacy Benefits are reduced to 75% of the Allowable Charge for the drugs, less the applicable Copayment or Coinsurance.

- Benefits for Prescription Drugs are available to the Covered Person only:

  — in accordance with a Prescription Order; and

  — after the Covered Person has Incurred charges equal to the Copayment or Coinsurance applicable to each Prescription Order. **If the charge for your Prescription is less than your Copayment or Coinsurance you will pay the lesser amount.**

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

  — Up to a 34–day supply or 120 unit doses (whichever is less) for "non–maintenance" drugs; or

  — Up to a 90–day supply or 360 unit doses (whichever is less) for nitroglycerin, natural thyroid products, and other drugs designated by the Claims Administrator as "maintenance" legend Prescription Drugs.

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

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

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

PHARMACY DISCOUNT PROGRAMS

In an effort to help offset the rising cost of Prescription Drugs, drug manufacturers may offer coupons or other drug discounts or rebates to Covered Persons, which may impact the Benefits provided under this program. The total Benefits payable will not exceed the balance of the Allowable Charges remaining after all drug coupons, rebates or other drug discounts have been applied. You agree to reimburse the Plan any excess amounts for Benefits that it has paid and for which you are not eligible due to the application of drug coupons, rebates or other drug discounts.

Schedule of Benefits
Covered Dental Services

This section shows how much the Plan pays for Covered Services described in the ***"Covered Dental Services"*** section that follows. It also explains the Coinsurance you must pay before the Plan starts to pay for most Covered Services. **Please note that services must be Medically Necessary in order to be covered under this program.**

BENEFIT PERIOD	Calendar Year
DEDUCTIBLE	$50 per Benefit Period per Covered Person for Basic and Major Services combined. The Deductible does not apply to Preventive or Orthodontia Services.
ORTHODONTIA DEDUCTIBLE	$50 per Benefit Period per Covered Person.
MAXIMUM	
Preventive, Basic and Major Services	$1,500 per Benefit Period per Covered Person.
Orthodontia Services	$1,500 per lifetime per Covered Person.
LIMITATIONS ON FREQUENCY AND AGE	• Benefits for exams, cleanings and fluoride treatments are limited to two per Calendar Year. • Benefits for full–mouth and bite–wing x–rays are limited to once per Calendar Year. • Bridges and dentures shall be replaced only when functionally necessary and at intervals of at least five years, unless damaged beyond repair because of injury to the mouth.
BENEFIT PERCENTAGE AMOUNT	The following chart shows the amount of Allowable Charges covered by the Plan through payments and/or contractual arrangements with Dentists. These amounts apply only after your Deductible and/or Coinsurance has been satisfied. The Benefit percentage shown is applicable to Covered Services received from a BlueTraditional Dentist or an Out–of–Network Dentist. However, Covered Persons who receive Covered Services from Out–of–Network Dentists may be responsible for amounts which exceed the Allowable Charge, in addition to the Deductible and/or Coinsurance amounts.

COVERED SERVICES (Subject to the *Covered Dental Services* section which follows)	BENEFIT PERCENTAGE AMOUNT:
Preventive Services	100% of the Allowable Charge for Covered Services.
Basic Services	80% of the Allowable Charge for Covered Services.
Major Services	50% of the Allowable Charge for Covered Services.
Orthodontia Services	50% of the Allowable Charge for Covered Services.

Covered Dental Services

The Plan pays the scheduled amounts for the following Covered Services you receive from a Dentist, **subject to the Limitations on Frequency or Age** shown in the preceding ***Schedule of Benefits***.

Diagnostic and Preventive Services

Dental exams, cleaning of teeth, full−mouth and bite−wing x−rays, fluoride treatments and space maintainers.

Basic Services

Amalgam fillings, restorations, oral Surgery, anesthesia, periodontics, endodontics, extractions, recementing bridges, crowns or inlays, dental sealants and emergency palliative pain treatment and x−rays.

Major Services

Gold or porcelain restorations, including inlays, crowns, prosthodontics, repair of crowns, bridgework, removable dentures, and rebasing or relining of removable dentures.

Major Services are available only to persons who have been covered under this Plan for at least 12 months.

Orthodontia Services

Examination, consultations, cephalometric x−rays, study models, installation and adjustment of active appliances in order to move teeth for the correction of faulty position of teeth (malposition) or abnormal bite (malocclusion).

Orthodontia Services are available only to Covered Persons under the age of 19 who have been covered under this Plan for at least 12 months.

Expenses Not Covered

In addition to the exclusions outlined in the ***"Exclusions"*** section of this Plan Summary, no Benefits will be provided under the ***"Covered Dental Services"*** section for services, supplies or charges:

- Covered as eligible medical expenses.
- For orthodontia services for persons age 19 or over.
- Which are not prescribed by or performed by or upon the direction of a Dentist.
- Received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar person or group.
- For prosthetic devices, including dentures (full or partial) and crowns (fixed or removable) or their fitting, which are prescribed and/or installed prior to the person's Effective Date or subsequent to their termination date under the Plan.
- For replacement of lost, missing, or stolen dentures or appliances, or the repair of appliances damaged while not in the mouth.

- For which charges would not have been made if no coverage existed or for which there is no charge to the patient.
- Mainly for cosmetic or aesthetic purposes.
- For local infiltration and block anesthesia used in connection with oral surgical services.
- For dental implant services.
- Which are not necessary according to broadly accepted standards of dental practice, including, but not limited to, services and supplies which are Experimental in nature.
- For special, non−standard techniques in denture construction to the extent the charge exceeds the charge for standard techniques.
- For the extraction of wisdom teeth or treatment of accidental injury during the six months immediately following the date of the injury. (These procedures are covered under the medical Benefits portion of this Plan).
- For treatment of temporomandibular joint disorder or dysfunction.
- Other than those specifically listed as ***Covered Dental Services*** under this Plan.

Covered Vision Care Services

The Plan covers Vision Care Services as follows:

- Benefits are not subject to the Deductible.
- Benefits are payable at 100% up to $200 per Covered Employee per Calendar Year.
- Benefits are payable at 100% up to $100 per Covered Dependent per Calendar Year.
- Covered Services are limited to eye examinations, lenses and frames, or contacts.
- Benefits are payable at 100% for newborn Covered Dependents per Calendar Year.
- All receipts from prior year are due by March 31st of the following year.

All claims for vision Benefits should be submitted to:

The Hawthorn Group
Attention: Benefits
808 North 161st East Avenue
Tulsa, OK 74116

You may call the following number if you have questions about your vision Benefit:

(918) 270–9455

Exclusions

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. It also explains the Preexisting Condition provisions in your coverage.

What Is Not Covered

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

- Which are not prescribed by or performed by or upon the direction of a Physician or other Provider.
- Which the Claims Administrator determines are not Medically Necessary, except as specified.
- Received from other than a Provider.
- Which are in excess of the Allowable Charge, as determined by the Claims Administrator.
- Which the Claims Administrator determines are Experimental/Investigational in nature.
- For any illness or injury occurring in the course of employment if whole or partial compensation or benefits are or might have been available under the laws of any governmental unit; any policy of workers' compensation insurance; or according to any recognized legal remedy arising from an employer–employee relationship. This applies whether or not you claim the benefits or compensation or recover the losses from a third party.
  - — You agree to:
    - ○ pursue your rights under the workers' compensation laws;
    - ○ take no action prejudicing the rights and interests of the Plan; and
    - ○ cooperate and furnish information and assistance the Plan requires to help enforce its rights.
  - — If you receive any money in settlement of your employer's liability, regardless of whether the settlement includes a provision for payment of your medical bills, you agree to:
    - ○ hold the money in trust for the benefit of the Plan to the extent that the Plan has paid any Benefits or would be obligated to pay any Benefits; and
    - ○ repay the Plan any money recovered from your employer or insurance carrier.
- To the extent payment has been made under Medicare or would have been made if you had applied for Medicare and claimed Medicare benefits, or to the extent governmental units provide benefits (some state or federal laws may affect how we apply this exclusion).
- For any illness or injury suffered after the 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.
- For which you have no legal obligation to pay in the absence of this or like coverage.
- For cosmetic Surgery or complications resulting therefrom, including Surgery to improve or restore your appearance, unless:

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

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

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

- Received from a member of your immediate family.
- Received before your Effective Date.
- For any Inpatient care and services, including rehabilitation care and services, unless documentation can be provided that, due to the nature of the services rendered or your condition, you cannot receive safe or adequate care as an Outpatient.
- Received after your coverage stops.
- For personal hygiene and convenience items regardless of whether or not recommended by a Physician or other Provider. Examples include: computers; air conditioners; air purifiers or filters; humidifiers; physical fitness equipment, including exercise bicycles or treadmills; or modifications to your home or vehicle.
- For telephone consultations, email or other electronic consultations, missed appointments, or completion of a claim form.
- For Custodial Care such as sitters' or homemakers' services, care in a place that serves you primarily as a residence when you do not require skilled nursing, or for rest cures.
- For foot care only to improve comfort or appearance such as care for flat feet, subluxation, corns, bunions (except capsular and bone Surgery), calluses, toenails, and the like.
- For routine, screening or periodic physical examinations, except as specified in the ***Comprehensive Health Care Services*** section.
- For female contraceptive devices when not prescribed by a licensed Provider, including over–the–counter contraceptive products. Contraceptive medications or devices for male use are excluded.
- For Orthognathic Surgery, osteotomy, or any other form of oral Surgery, dentistry, or dental processes to the teeth and surrounding tissue (including complications resulting therefrom), except for:

  — the treatment of accidental injury to the jaw, sound natural teeth, mouth or face; or

  — for the improvement of the physiological functioning of a malformed body member, provided the Covered Person has been continuously covered under this Plan since birth.

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

- Those specified under the ***Covered Dental Section*** of this Plan.
- 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:

  — severely disabled; or

— eight years of age or under;

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

- For eyeglasses, contact lenses or examinations for prescribing or fitting them, except for aphakic patients (including lenses required after cataract Surgery) and soft lenses or sclera shells to treat disease or injury. Vision examinations not related to the prescription or fitting of lenses will be a Covered Service only when performed in connection with the diagnosis or treatment of disease or injury. Eye refractions are not covered in any event.
- For eye Surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).
- For hearing aids, tinnitus maskers, or examinations for prescribing or fitting them, except as specified in the ***Schedule of Benefits Comprehensive Health Care Services*** section. Hearing examinations not related to the prescription or fitting of hearing aids will be a Covered Service only when performed in connection with the diagnosis or treatment of disease or injury.
- For Ventricular Assist Devices.
- For transsexual Surgery or any treatment leading to or in connection with transsexual Surgery.
- For diagnosis, treatment or medications for infertility and fertilization procedures. Examples include any form of: artificial insemination; ovulation induction procedures; in vitro fertilization; embryo transfer; or any other procedures, supplies or medications which in any way are intended to augment or enhance your reproductive ability.
- For treatment of sexual problems not caused by organic disease.
- For treatment of obesity, regardless of the patient's history or diagnosis, including surgical procedures and any complications resulting from weight loss treatments or procedures, except as provided for as a Preventive Care Service.
- For or related to acupuncture, whether for medical or anethesia purposes..
- For conditions related to autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems, mental retardation, or for Inpatient confinement for environmental change, except for drugs used to treat attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD).
- For unspecified developmental disorders or autistic disease of childhood, except as specified.
- For or related to applied behavior analysis.
- For Inpatient drug and alcohol treatment that is not rendered in a Hospital, Psychiatric Hospital, Residential Treatment Center or other Plan–approved Provider.
- For family or marital counseling.
- For hippotherapy, equine assisted learning, or other therapeutic riding programs.
- For which the Provider of service customarily makes no direct charge to a Covered Person.
- Received from a Skilled Nursing Facility, Home Health Care Agency, Hospice, or rehabilitation facility which is not a Plan–approved Provider.
- For or related to transplantation of donor organs, tissues or bone marrow, except as specified under ***"Human Organ, Tissue and Bone Marrow Transplant Services"***.

- For Physician standby services.
- For Continuous Passive Motion (CPM) devices used in treatment of the shoulder or other joints, except for up to 21 days postoperatively for the following surgical procedures: total knee arthroplasty, anterior cruciate ligament reconstruction, or open reduction and internal fixation of tibial plateau for distal femur fractures involving the knee joint.
- For ductal lavage of the mammary ducts.
- For extracorporeal shock wave treatment, also known as orthotripsy, using either a high– or low–dose protocol, for treatment of plantar fasciitis and all other musculoskeletal conditions.
- For orthoptic training.
- For thermal capsulorraphy as a treatment of joint instability, including but not limited to instability of shoulders, knees and elbows.
- For transcutaneous electrical nerve stimulator (TENS).
- For services rendered by midwives.
- For massage therapy, including but not limited to effleurage, petrissage and/or tapotement.
- Which are not specifically named as Covered Services subject to any other specific Exclusions and limitations in this 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 our rights under this provision.

Preexisting Condition Exclusion

Your Benefits under the Plan are subject to a Preexisting Condition Exclusion period. However, the Preexisting Condition Exclusion will only apply to you and/or a Dependent if the following conditions are met:

- **Six–month Look–back Rule**
  - — The Preexisting Condition Exclusion must relate to a condition (whether physical or mental, and regardless of the cause of the condition) for which medical advice, diagnosis, care, or treatment was recommended or received within the six–month period ending on the Covered Person's Enrollment Date.
  - — In order to be taken into account, the medical advice, diagnosis, care, or treatment must have been recommended or received from an individual licensed or similarly authorized to provide such services under state law and operating within the scope of practice authorized by state law.
  - — The six–month look–back period is based on the six–month "anniversary date" of the Enrollment Date.
- **Length of Preexisting Condition Exclusion Period**

  The exclusion period cannot extend for more than 12 months (18 months for Late Enrollees*) after the Enrollment Date. The 12–month or 18–month "look forward" period is also based on the anniversary date of the Enrollment Date.
- **Reduction of Preexisting Condition Exclusion Period by Prior Coverage**

  In general, the Preexisting Condition Exclusion period must be reduced by the individual's days of "Creditable Coverage" as of the Enrollment Date. Creditable Coverage includes coverage from a wide range of specified

sources, including Group Health Plans, health insurance coverage, Medicare, and Medicaid. However, days of Creditable Coverage that occur before a Significant Break In Coverage (63 or more consecutive days) will not be counted in reducing the Preexisting Condition Exclusion period.

In addition, the Preexisting Condition Exclusion period will be *waived* for an individual with prior Creditable Coverage through a Health Maintenance Organization, and who Enrolls under this Plan without a Significant Break In Coverage.

- **Elimination of Preexisting Condition Exclusion for Pregnancy and for Certain Children**

  A Preexisting Condition Exclusion cannot apply to pregnancy. In addition, a Preexisting Condition Exclusion period will not be applied to Covered Persons under age 19.

- **Notice to Covered Persons**

  The Plan may only impose a Preexisting Condition Exclusion with respect to a Covered Person by notifying the Covered Person, in writing, of the existence and terms of any Preexisting Condition Exclusion under the Plan and of the rights of the Covered Person to demonstrate Creditable Coverage. The Plan will assist the Covered Person in obtaining a Certificate of Coverage from any prior health plan or issuer, if necessary.

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

[*] *See the **Definitions** section for an explanation of this term.*

General Provisions

This section tells:

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

Benefits to Which You Are Entitled

The Plan provides only the Benefits specified in this benefit booklet.

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 booklet will be covered only for those Providers specified in this benefit booklet.

Prior Approval

The Claims Administrator does not give prior approval or guarantee Benefits for any services through its Precertification 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 90 days after the end of the Benefit Period for which claim is made.

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 within 60 days after a Properly Filed Claim has been made. No such action may be taken later than three years after expiration of the time within which a Properly Filed Claim is required by 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 under this benefit booklet. 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 this benefit booklet will be based upon the Allowable Charge (as the Claims Administrator determines) for Covered Services. A BlueChoice PPO Provider will accept the Allowable Charge as payment in full and will make no additional charge to you for Covered Services. However, if you receive Covered Services from an Out−of−Network Provider, you may be responsible for amounts which exceed the Allowable Charge, in addition to the Deductible and/or Coinsurance amounts.

In some cases, Covered Services may be rendered by a Provider who has a Participating Provider Agreement (*other than a BlueChoice PPO Provider Agreement)* with the Plan. These Providers (called BlueTraditional Providers) have agreed to charge Plan Covered Persons no more than a "Maximum Reimbursement Allowance" for Covered Services. Covered Persons who use BlueTraditional Providers are responsible for amounts over the "Allowable Charge," *up to but not exceeding* the "Maximum Reimbursement Allowance" specified in the Provider's Participating Provider Agreement.

Benefits for Services Outside the State of Oklahoma

All Blue Cross and Blue Shield Plans participate in a national program called the "BlueCard Program". This national program benefits 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 Blue Cross and/or Blue Shield 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 Blue Cross method noted in the above paragraph or require a surcharge, Blue Cross and Blue Shield of Oklahoma would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

NOTE: Blue Cross and Blue Shield of Oklahoma may postpone application of your Deductible and/or Coinsurance 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 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 booklet.

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 consultant or panel of Physicians 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 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 are not employees, agents or other legal representatives of Blue Cross and Blue Shield 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 "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 this benefit booklet are subject to this provision.

- **Definitions**

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

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

— Group, blanket or franchise insurance coverage;

— Blue Cross Plan, Blue Shield Plan, Health Maintenance Organization, and other prepayment coverage;

— Coverage under labor–management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans;

— Coverage toward the cost of which any employer has contributed, or with respect to which any employer has made payroll deduction; and

— Coverage under any tax supported or government program to the extent permitted by law.

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

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

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

- **Effect On Benefits**

  If the total Benefits for Covered Services to which you would be entitled under the Plan and all Other Contracts exceed the Covered Services you receive in any Benefit Period, then the Benefits the Plan provides for that Benefit Period 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 this 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 Contract 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

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 this 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. Our acceptance of your premiums or payment of Benefits under this Plan does not waive our rights to enforce these provisions in the future.

To the extent the Plan provides or pays Benefits for Covered Services for any injury, illness or condition which occurs through the omission or commission of any act by another person, each Covered Person agrees that the Plan shall have a first lien on any settlement proceeds, and the Covered Person shall reimburse and pay the Plan, on a first−priority basis, from any money recovered by suit, settlement, judgment or otherwise from another party or his or her insurer or from any carrier providing uninsured/underinsured motorist coverage. Each Covered Person shall reimburse the Plan on a first−priority basis regardless of whether a lawsuit is actually filed or not and, if settled, regardless of how the settlement is structured or which items of damages are included in the settlement, and regardless of whether or not he or she is made whole or is fully compensated for any injuries.

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

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

Limitations on Plan's Right of Recoupment/Recovery

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

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

Claims Administrator's Separate Financial Arrangements with Pharmacy Benefit Managers

The Claims Administrator owns a significant portion of the equity of Prime Therapeutics LLC and informs you that the Claims Administrator has entered into one or more agreements with Prime Therapeutics LLC or other entities (collectively referred to as "Pharmacy Benefit Managers") to provide, on the Claims Administrator's behalf, claim payments and certain administrative services for your Prescription Drug Benefits. Pharmacy Benefit Managers have agreements with pharmaceutical manufacturers to receive rebates for using their products. The Pharmacy Benefit Manager may share a portion of those rebates with the Claims Administrator. Neither the Employer nor you are entitled to receive any portion of such rebates as they are figured into the pricing of the product.

Claims Filing Procedures

The Plan begins to pay only after the Copayment 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 Copayment 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 Copayment and/or Deductible. Then the Claims Administrator's records will show that you have Incurred the Copayment and/or Deductible amount, and your health care coverage will begin to help pay the balance of your eligible expenses.

Participating Provider Networks

Participating Providers have agreed to submit claims directly to the Claims Administrator for you. When you receive Covered Services from a network Provider, simply show your Identification Card, and claims submission will be handled for you. If you must use 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 care program, you must receive treatment from the 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 should pay the Hospital yourself and then file a claim for Covered Hospital Services.

Ambulatory Surgical Facility Claims

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

Physician and Other Provider Claims

If you are treated by a Physician or other Provider who does not have an agreement with 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 Coinsurance amounts which apply to your coverage.

Employee–Filed Claims

When you must file a claim yourself, you may obtain claim forms by contacting the nearest Claims Administrator's office.

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

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

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

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

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

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

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

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

Remember, the Claims Administrator must receive your claims for Covered Services within 90 days after the end of the Benefit Period for which claim is made.

Dental Claims

A Participating Dentist will file your claim for you. If you receive services from an Out–of–Network Dentist, you should arrange to pay the Dentist yourself and then file a claim. You will be paid directly for Covered Services after the Claims Administrator subtracts your shared payment.

Mail the completed claim form to:

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

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 Procedure***."

DIRECT CLAIMS LINE

The Claims Administrator has a direct line for claims and membership inquiries. You may call 1–800–672–2567 between 8:00 a.m. and 6:00 p.m., Monday through Friday, whenever you have a question concerning a claim or your membership.

Complaint/Appeal Procedure

The Claims Administrator has established the following process to review your dissatisfactions, complaints and/or appeals. If you have designated an authorized representative, that person may act on your behalf in the appeal process.

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

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

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 Booklet 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 as described in "Claim Appeal Procedures" below.

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

- The reasons for determination;
- A reference to the Group Health Plan 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 Claims Administrator's internal review/appeals and external review processes (and how to initiate a review/appeal or external review) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on internal review/appeal;
- 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;

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

Timing of Required Notices and Extensions

Separate schedules apply to the timing of required notices and extensions, depending on the type of claim. There are three types of claims as defined below.

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

- **"Pre−Service Claim"** is any non−urgent request for Benefits or a determination with respect to which the terms of the Benefit plan condition receipt of the Benefit on approval of the Benefit in advance of obtaining Medical Care.

- **"Post−Service Claim"** is any request for a Benefit that is not a "pre−service" claim, and whereby notification that a service has been rendered or furnished to you is submitted to the Claims Administrator in an acceptable form. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the claim charge, and any other information which the Claims Administrator may request in connection with services rendered to you.

URGENT CARE CLINICAL CLAIMS*

Type of Notice or Extension	Timing
If your claim is incomplete, the Claims Administrator must notify you within:	**24 hours**
If you are notified that your claim is incomplete, you must then provide completed claim information to the Claims Administrator within:	**48 hours** after receiving notice
The Claims Administrator must notify you of the claim determination (whether adverse or not):	
if the initial claim is complete as soon as possible (taking into account medical exigencies), but no later than:	**72 hours**
after receiving the completed claim (if the initial claim is incomplete), within:	**48 hours**

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

PRE–SERVICE CLAIMS

Type of Notice or Extension	Timing
If your claim is filed improperly, the Claims Administrator must notify you within:	**5 days**
If your claim is incomplete, the Claims Administrator must notify you within:	**15 days**
If you are notified that your claim is incomplete, you must then provide completed claim information to the Claims Administrator within:	**45 days** after receiving notice
The Claims Administrator must notify you of the claim determination (whether adverse or not):	
if the initial claim is complete, within:	**15 days***
after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
If you require post–stabilization care after an Emergency within:	**the time appropriate to the circumstance not to exceed one hour after the time of request**

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

POST–SERVICE CLAIMS

Type of Notice or Extension	Timing
If your claim is incomplete, the Claims Administrator must notify you within:	**30 days**
If you are notified that your claim is incomplete, you must then provide completed claim information to the Claims Administrator within:	**45 days after receiving notice**
The Claims Administrator must notify you of the claim determination (whether adverse or not):	
if the initial claim is complete, within:	**30 days***
after receiving the completed claim (if the initial claim is incomplete), within:	**45 days**

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

Claim Appeal Procedures

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

  An "**Adverse Benefit Determination**" means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Benefit, including any such denial, reduction, termination, or failure to provide or make payment for, a Benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which Benefits are otherwise provided because it is determined to be

Experimental or Investigational or not Medically Necessary or appropriate. If an ongoing course of treatment had been approved by the Claims Administrator or your Employer and the Claims Administrator or your Employer reduces or terminates such treatment (other than by amendment or termination of the Employer's Benefit 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 your Employer at the completion of the Claims Administrator's or Employer's internal review/appeal process.

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

If your situation meets the definition of an Expedited Clinical Appeal, you may be entitled to an appeal on an expedited basis. An **Expedited Clinical Appeal** is an appeal of a clinically urgent nature related to health care services, including but not limited to, procedures or treatments ordered by a health care Provider, as well as continued hospitalization. Before authorization of Benefits for an ongoing course of treatment/continued hospitalization is terminated or reduced, 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 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 as soon as possible (taking into account medical exigencies), but no later than 72 hours after it receives the initial request, or within 48 hours after it receives the missing information (if the initial request is incomplete).

- ***How to Appeal an Adverse Benefit 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 your Group Health Plan.

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

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 Administrative 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
Blue Cross and Blue Shield of Oklahoma
P. O. Box 3283
Tulsa, Oklahoma 74102−3283

— 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 your Employer.

— If you have any questions about the claims procedures or the review procedure, write to the Claims Administrator's Administrative Office or call the toll–free Customer Service number shown in this Benefit Booklet or on your Identification Card.

- ***Timing of Appeal Determinations***

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

Upon receipt of a non–urgent post–service appeal, the Claims Administrator shall render a determination of the appeal as soon as practical, but in no event more than 60 days after the appeal has been received by the Claims Administrator.

- ***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 Benefit Plan provisions on which the determination is based, or the contractual, administrative or protocol for the determination;

— Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care Provider, claim amount (if applicable), and 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) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on external appeal;

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

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

— 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.

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

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 four 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, four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth 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 five 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 we complete the preliminary review if your request is eligible or if further information or documents are needed. You will have the remainder of the four−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, we will outline the reasons it is ineligible in the notice, and provide contact information for the Department of Labor's Employee Benefits Security Administration (toll−free number 866−444−EBSA (3272)).

- **Referral to Independent Review Organization.** If your request is eligible for external review and you submit the request 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 five 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 one 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 one 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 one 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 involve 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 to comply with the internal claims and appeals process, you also have the right to pursue any available remedies under 502(a) of ERISA or 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 Employer's Plan Provisions

The Plan Administrator has given the Claims Administrator the initial authority to establish or construe the terms and conditions of the Health Benefit Plan and the discretion to interpret and determine Benefits in accordance with the Health Benefit Plan's provisions.

The Plan Administrator has all powers and authority necessary or appropriate to control and manage the operation and administration of the Health Benefit Plan.

All powers to be exercised by the Claims Administrator or the Plan Administrator shall be exercised in a non–discriminatory manner and shall be applied uniformly to assure similar treatment to persons in similar circumstances.

Definitions

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

Actively at Work

The active expenditure of time and energy in the services assigned by the Employer. You are considered Actively at Work on each day of a regular paid vacation, an Employer holiday, or on a regular nonworking day if you were Actively at Work on the work day before your Effective Date.

Allowable Charge

The charge that the 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 Comprehensive Health Care Services, the Allowable Charge is determined as follows:

- **BlueChoice PPO Provider** — the Provider's usual charge, not to exceed the amount the Provider has agreed to accept as payment for Covered Services in accordance with a BlueChoice PPO Provider Agreement.
- **Out–of–Network (Non–Contracting) Provider** — the lesser of: (a) the Provider's billed charge; or (b) the Claims Administrator's Non–Contracting Allowable Charge as set forth in the ***"Important Information"*** section.

For Outpatient Prescription Drug Benefits, the Allowable Charge is determined as follows:

- **Participating Pharmacy** — the Pharmacy's usual charge, not to exceed the amount the Pharmacy has agreed to accept as payment for Covered Services in accordance with a Participating Pharmacy Agreement.
- **Out–of–Network Pharmacy** — the Pharmacy's usual charge, not to exceed the amount that the Plan would reimburse a Participating Pharmacy for the same service.

NOTE: For Covered Services received outside the state of Oklahoma, the "Allowable Charge" will be determined by the Blue Cross and Blue Shield Plan (Host Plan) servicing the area. 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.

Benefit Period

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

Benefits

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

BlueCard Provider

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

BlueChoice PPO Provider

A Provider who has entered into an agreement with the 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.

Calendar Year

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

Certificate of Coverage

A document providing information which is intended to enable an individual to establish his/her prior Creditable Coverage for the purposes of reducing any Preexisting Condition Exclusion imposed on the individual by any subsequent Group Health Plan coverage.

COBRA Continuation Coverage

Coverage under the Plan for you and your eligible Dependent with respect to whom a Qualifying Event has occurred, and consisting of coverage which, as of the time the coverage is being provided, is identical to the coverage provided under the Plan to Covered Persons to whom a Qualifying Event has not occurred.

Coinsurance

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

Community Home Health Care Agency

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

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.

Copayment

A fixed dollar amount required to be paid by or on behalf of a Covered Person in connection with the delivery of Covered Services in a BlueChoice PPO or BlueCard PPO Physician's office.

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 Service

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

Creditable Coverage

Coverage of an individual from a wide range of specified sources, including Group Health Plans, health insurance coverage, Medicare, and Medicaid.

Custodial Care

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

Deductible

A specified amount of Covered Services that you must incur before the Plan will start to pay its share of the remaining Covered Services.

Dentist

A professional practitioner who holds a lawful license issued by any state of the United States, or its territories, authorizing the person to practice dentistry and dental Surgery in such state or territory, including, but not limited to, a Doctor of Dental Surgery (DDS) or a Doctor of Medical Dentistry (DMD).

Dependent

A Covered Person other than the Employee as shown in the ***Eligibility, Enrollment, Changes and Termination*** section.

Diagnostic Service

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

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

Durable Medical Equipment

Equipment 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.

Effective Date

The date when your coverage begins.

Eligible Person

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

Emergency Care

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

- serious jeopardy to the Covered Person's health;

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

EMPLOYEE

An Eligible Person as specified in the ***Eligibility, Enrollment, Changes and Termination*** section.

EMPLOYER

The Hawthorn Group

ENROLL

To become covered for Benefits under the Plan (i.e., when coverage becomes effective), without regard to when the individual may have completed or filed any forms that are required in order to Enroll for coverage.

ENROLLMENT DATE

The first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period (typically the date employment begins).

EXPERIMENTAL/INVESTIGATIONAL

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

FAMILY COVERAGE

Coverage under the Plan for the Member and one or more of the Employee's Dependents.

GENERIC DRUG

Pharmaceutically equivalent drug products substituted for the originator/trademarked (brand) drug products.

GROUP

A classification of coverage whereby a corporation or other legal entity has agreed to establish a premium collection and payment system in order to provide an opportunity for its employees to acquire Plan coverage for dental care expenses.

GROUP HEALTH OR DENTAL PLAN

A plan (including a self–insured plan) of, or contributed to by, an employer (including a self–employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families.

HEALTH CARE ACCOUNT

BlueEdge HCA is an Employer funded reimbursement that pays for the initial qualified medical expenses of the Deductible.

Hospice

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

Hospital

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

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

Hospital Admission

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

Identification Card

The card issued to the Employee by the Claims Administrator, bearing the Employee's name, identification number, and the Plan.

Incurred

A charge is Incurred on the date you receive a service or supply for which the charge is made.

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.

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 Outpatient Program

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

Late Enrollee

An Eligible Person or eligible Dependent who Enrolls under the Plan at a time other than during:

- the Initial Enrollment Period; or
- a Special Enrollment Period for the individual.

However, an Eligible Person or Eligible Dependent is not considered a Late Enrollee if a court has ordered coverage be provided for a spouse or minor or Dependent child under the Eligible Person's coverage and the request for enrollment is made within 31 days after issuance of the court order.

Licensed Practical or Vocational Nurse (LPN or LVN)

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

Low-Dose Mammography

The x–ray screening examination of the breast using equipment dedicated specifically for mammography, including but not limited to the x–ray tube, filter, compression device, screens, films, and cassettes, with an average radiation exposure delivery of less than one rad mid–breast, with two views for each breast.

Maternity Services

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

Medical Care

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

Medically Necessary (or Medical Necessity)

Health care services that a Hospital, Physician, or other Provider exercising prudent clinical judgement, 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.

Non-Preferred Brand Drug

A name−brand Prescription Drug which has not been designated by the Claims Administrator as a Preferred Drug.

Open Enrollment Period

An Open Enrollment Period will be held each year during a period designated by the Plan Sponsor, prior to the Plan's anniversary date.

Orthognathic Surgery

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

Out-of-Network Pharmacy

A Pharmacy that has not entered into a Participating Pharmacy Agreement with the Claims Administrator.

Out-of-Network Provider

A Provider that has not entered into an agreement with the Claims Administrator to be a part of its BlueChoice PPO or BlueCard PPOProvider networks.

Out-of-Pocket Limit

A specified dollar amount of Covered Services which are reimbursed at less than 100% of the Allowable Charge to or on behalf of a Covered Person during a Benefit Period. When the Out−of−Pocket Limit is reached, the level of Benefits is increased as specified in the ***Schedule of Benefits***.

Outpatient

A Covered Person who receives services or supplies while not an Inpatient.

Participating Pharmacy

A Pharmacy that has entered into a Participating Pharmacy Agreement with the Claims Administrator.

Pharmacy

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

Physician

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

Placement for Adoption (or Placed for Adoption)

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

Plan

This Plan of Benefits for ***Covered Comprehensive Health Care Services***, ***Outpatient Prescription Drug Benefits***, and ***Covered Dental Services*** provided by and through th eEmployer, as set forth herein.

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.

Preexisting Condition

A condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six−month period ending on the Enrollment Date. In order to be taken into account, the medical advice, diagnosis, care, or treatment must have been recommended by or received from an individual licensed or similarly authorized to provide such services under state law and operating within the scope of practice authorized by the state law. A Preexisting Condition does not include pregnancy, nor can it be applied to Covered Persons under age 19.

Preferred Drug

A Prescription Drug which has been designated by the Claims Administrator to be a part of its Preferred Prescription Drug Program.

Prescription Drug

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

Prescription Order

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

Properly Filed Claim

A formal statement or claim regarding a loss which provides sufficient, substantiating information to allow the 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 disorder.

Qualifying Event

Any one of the following events which, but for the COBRA Continuation Coverage provisions of the Plan, would result in the loss of a Covered Person's coverage:

- The death of the covered Employee;
- The termination (other than by reason of a covered Employee's gross misconduct), or reduction of hours, of the covered Employee's employment;
- The divorce or legal separation of the covered Employee from the Employee's spouse;
- The covered Employee becoming entitled to benefits under Medicare;
- A Dependent child ceasing to be eligible as defined under the Plan.

Registered Nurse (RN)

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

Residential Treatment Center

A state licensed and/or state certified facility that provides a 24−hour level of residential care to patients with long−term or Severe Mental Illnesses and/or substance abuse disorders. The care is medically monitored, with 24−hour Physician availability and 24−hour onsite nursing services.

Retail Pharmacy Vaccination Network

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

Routine Nursery Care

Ordinary Hospital nursery care of the newborn Covered Person.

Significant Break In Coverage

A period of 63 consecutive days during all of which the individual did not have any Creditable Coverage, except that neither a Waiting Period nor an affiliation period is taken into account in determining a Significant Break In Coverage.

Special Enrollment Period

A period during which an individual who previously declined coverage is allowed to Enroll under the Contract without having to wait until the Group's next regular Open Enrollment Period.

Specialty Pharmacy Drugs

Prescription Drugs that meet at least two of the following criteria:

- they are high cost;
- they are for use in limited patient populations or indications;
- they are typically self–injected;
- they have limited availability, require special dispensing, or delivery and/or patient support is required and, therefore, they are difficult to obtain via traditional Pharmacy channels;
- complex reimbursement procedures are required; and/or
- a considerable portion of the use costs are frequently generated through office–based medical claims.

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.

Therapy Service

The following services and supplies ordered by a Physician when used to treat and promote your recovery from an illness or injury:

- **Radiation Therapy** — the treatment of disease by x–ray, radium, or radioactive isotopes.
- **Chemotherapy** — the treatment of malignant disease by chemical or biological antineoplastic agents, but not including High–Dose Chemotherapy. High–Dose Chemotherapy is specifically addressed in certain sections under ***"Human Organ, Tissue and Bone Marrow Transplant Services."***
- **Respiratory Therapy** — introduction of dry or moist gases into the lungs for treatment purposes.
- **Dialysis Treatment** — the treatment of an acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body to include hemodialysis or peritoneal dialysis.

- **Physical Therapy** — the treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio–mechanical and neuro–physiological principles, and devices to relieve pain, restore maximum function, and prevent disability following disease, injury, or loss of body part.

- **Occupational Therapy** — treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those required by the person's particular occupational role.

- **Speech Therapy** — treatment for the correction of a speech impairment resulting from disease, Surgery, injury, congenital and developmental anomalies, or previous therapeutic processes.

Total Disability (or Totally Disabled)

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

- The Covered Person is unable to perform the substantial duties of any occupation or business for which he/she is qualified and the Covered Person is not in fact engaged in any occupation for wages or profit; or

- If the Covered Person does not usually work for wages or profit, the Covered Person cannot do the normal activities of a person of the same age and sex.

Waiting Period

The period that must pass before an Eligible Person or Dependent is eligible to Enroll under the terms of a Group Health Plan. If an Eligible Person or Dependent Enrolls as a Late Enrollee or during a Special Enrollment Period, any period before such late or special enrollment is not a Waiting Period.

Information Provided By Your Employer

Employee Retirement Income Security Act of 1974 (ERISA)

The following information comprises the Summary Plan Description under the Employee Retirement Income Security Act of 1974:

PLAN NAME

The name of the Plan is The Hawthorn Group Employee Benefit Plan.

TYPE OF PLAN

Employee Welfare Benefit Plan

EFFECTIVE DATE

This Plan Document shall be in full force and effect beginning on the first day of January, 2013. This Plan Document and any amendments or modifications thereto, shall remain in full force and effect until either replaced by a new Plan Document or the Plan terminates.

PLAN ADMINISTRATOR AND PLAN SPONSOR

The Hawthorn Group
808 North 161st East Avenue
Tulsa, Oklahoma 74116
(918) 270-9455

PLAN NUMBER

501

EMPLOYER IDENTIFICATION NUMBER

74-3073830

NAMES AND ADDRESSES OF THE PLAN TRUSTEES

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Robert Ragan
c/o The Hawthorn Group
808 North 161st East Avenue
Tulsa, Oklahoma 74116

AGENT FOR SERVICE OF LEGAL PROCESS

Mike Dargel
c/o The Hawthorn Group
808 North 161st East Avenue
Tulsa, Oklahoma 74116

In addition to the forgoing, service may be made upon any Trustee or the Plan Administrator.

PLAN YEAR

The Plan's records are maintained on a plan year basis ending December 31 each year.

FUNDING

The Plan is funded by contributions to The Hawthorn Group, Employee Group Benefit Trust (the "Trust") made by The Hawthorn Group, its affiliates and Covered Persons. All benefits of the Trust are provided from the assets accumulated under the Trust for this purpose.

All Plan Benefits are paid first out of Covered Persons' contributions to the Plan and the balance from Employer contributions.

TYPE OF ADMINISTRATION

Contract administration performed by the Claims Administrator, at the direction of the Plan Administrator. Name, address and telephone number of the Claims Administrator:

Blue Cross and Blue Shield of Oklahoma
P.O. Box 3283
Tulsa, Oklahoma 74102-3283
(918) 586-7700

CLAIMS PROCEDURES

Claims for Benefits under the Plan are to be submitted to the Claims Administrator (BCBSOK) as provided in the Plan Summary. Payment of claims under the Plan will be made by the Claims Administrator on behalf of the Employer. If an Employee's claim for Benefits under the Plan is denied, the Claims Administrator will provide notice to the Employee in writing of the denial within a reasonable time setting forth the specific reasons for such denial. The Employee may then request a review of the decision denying a claim. Such request for a review must be made in writing.

RIGHTS AND PROTECTIONS

As a participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

- **Receive Information about Your Plan and Benefits**

  Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

  Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.

  Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

- **Continue Group Health Plan Coverage**

  Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

  Reduction or elimination of exclusionary periods of coverage for Preexisting Conditions under your Plan, if you have Creditable Coverage from another plan. You should be provided a certificate of Creditable Coverage, free of charge, from your Group Health Plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA Continuation Coverage,

when your COBRA Continuation Coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of Creditable Coverage, you may be subject to a Preexisting Condition Exclusion for 12 months (18 months for late enrollees) after your Enrollment Date in your coverage.

- **Prudent Actions by Plan Fiduciaries**

  In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

- **Enforce Your Rights**

  If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator (your Employer) to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for Benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

  In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

- **Assistance with Your Questions**

  If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PLAN ADMINISTRATOR'S RIGHTS

The right is reserved in the Plan for the Plan Administrator to terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time. The Plan Sponsor does not promise the continuation of any Benefits nor does it promise any specific level of Benefits at or during retirement. Any Benefits, rights, or obligations of Covered Persons following termination from the Plan are described in detail herein.

Administered by:

BlueCross BlueShield of Oklahoma

Experience. Wellness. Everywhere.[SM]

www.bcbsok.com

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