Your Health Care Benefit Program

Blue Preferred PPO
Summary of Benefits

Effective June 1, 2025

Flintco, LLC
Group Health Plan

BlueCross BlueShield of Oklahoma

Experience. Wellness. Everywhere.℠

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Table of Contents

About this Summary

This benefit booklet is intended to be the Plan and combined Summary Plan Description. It is provided according to the terms of the Flintco, LLC Group Health Plan ("Plan") – a part of the Flintco, LLC Welfare Benefit Plan. It contains the principal provisions of the Plan and its ***Medical Benefits Summary*** and its ***Prescription Drug Benefits Summary***.
If a word or phrase starts with a capital letter, it has a special meaning in this Summary. It is defined in the ***Definitions*** section where used in the text, or it is a title.

Your Plan has contracted with **Blue Cross and Blue Shield of Oklahoma** (sometimes in this Summary called we, us, or our) to act as Claims Administrator and provide other services on behalf of the Plan Administrator in providing the Benefits described in this Summary.

The Plan applies the benchmark plan for Utah for determining "essential health benefits" under the Affordable Care Act. Essential health benefits are not subject to annual dollar limits, but other types of benefits may be subject to annual dollar limits.

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 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 BLUE PREFERRED PPO PROVIDER NETWORK

Blue Preferred 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 Blue Preferred coverage will provide the highest level of Benefits if you use a Blue Preferred PPO Provider.

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

HOW YOUR BLUE PREFERRED PPO COVERAGE WORKS

Your Blue Preferred 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 Blue Preferred PPO Provider.

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

COST SHARING FEATURES OF YOUR COVERAGE

As a participant in this Plan, you have the responsibility for sharing in a portion of your health care costs. You are responsible for the applicable 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 premiums, depending upon the terms of your Plan. Check with your Plan Administrator for specific premium amounts applicable to the coverage you have selected for you and your family.

SELECTING A NETWORK PROVIDER – BLUECARD PPO

There are several ways to find out whether or not a Hospital, Physician, or other Provider is a BlueCard PPO network Provider.

Upon enrollment, a directory of network Providers will be provided to you at no charge upon request. Providers are listed alphabetically and by specialty. The directory also indicates the Hospitals where each Physician practices. A listing of Oklahoma network Providers is also 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 network status.

When you call Blue Cross and Blue Shield of Oklahoma, ask our Customer Service Representative whether or not the Provider is a network Provider. Simply call our toll-free number at 1-800-942-5837.

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 Blue Preferred PPO Provider network**.

THE BLUECARD PPO PROGRAM

As a Blue Cross and Blue Shield Plan Member, you enjoy the convenience of carrying your Identification Card — The BlueCard. The BlueCard Program allows you to use a Blue Cross and Blue Shield 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. We'll help you locate the nearest PPO Physician or Hospital. *Remember, you are responsible for receiving Precertification 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 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 Precertification 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 Deductible and/or Coinsurance payments, if any.
- All PPO Physicians and Hospitals are paid directly, relieving you of any hassle and worry.

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

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

CONCURRENT REVIEW AND CASE MANAGEMENT

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

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

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

ALLOWABLE CHARGE

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

- Blue Preferred 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*.**

- Blue Cross and Blue Shield of Oklahoma will calculate your Benefits based on this "Allowable Charge." We 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. We will then determine your Benefits under this Summary, and direct any payment to your network Provider.

REMEMBER ...

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

Your coverage contains special provisions (Benefit reductions) which apply whenever you use Out-of-Network Providers. If you use an Out-of-Network Provider, your Benefits will be determined as follows:

- If you use an Oklahoma Out-of-Network Provider, the Plan will determine the Allowable Charge for your out-of-network claims **based upon the amount the Plan would have reimbursed an Oklahoma Blue Preferred PPO Provider for the same service**. 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" which a Blue Preferred PPO Provider would have accepted for the same services.

- 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, and the claim for those services is filed with the Blue Cross and Blue Shield Plan (Host Plan) servicing the area, the "Allowable Charge" will be determined by the Host Plan. This Allowable Charge will be the amount the Host Plan uses for their own local members that obtain services from local non-contracting Providers. 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.

- In instances where the claim is not filed with the Host Plan, the Allowable Charge for your out-of-network claims will be ***based upon what the Plan would have reimbursed a Blue Preferred PPO Provider for the same service.*** 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" which a Blue Preferred PPO Provider would have accepted for the same services.

- In certain instances, your services may be rendered by a Provider who has a Participating Provider Agreement (other than a Blue Preferred PPO Participating Agreement) with Blue Cross and Blue Shield of Oklahoma. These Providers (called BlueTraditional Providers) have agreed to charge Plan Covered Persons no more than a "Maximum Reimbursement Allowance" for Covered Services. If you receive Covered Services from a BlueTraditional 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*).

  — Any amounts over the "Allowable Charge" up to but not exceeding the "Maximum Reimbursement Allowance" specified in their Participating Provider Agreement.

Keep in mind that these "Allowable Charge" provisions apply whenever you obtain services outside the Blue Preferred PPO or BlueCard PPO Provider networks, including Emergency Care or referral services.

SPECIAL NOTICES

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

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 your Summary.

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

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. The Summary page has a space to record it.

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

DESIGNATING AN AUTHORIZED REPRESENTATIVE

The Plan has established procedures for you to designate an individual to act on your behalf with respect to a Benefit claim or an appeal of an Adverse Benefit Determination. Contact Employee Services at (918) 587-8451 for help if you wish to designate an authorized representative. In the case of a Precertification Request Involving Urgent Care, a health care professional with knowledge of your medical condition will be permitted to act as your authorized representative.

QUESTIONS

Whenever you call our 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 Summary. If you need more help, please call Employee Services at (918) 587-8451.

Or you can write:

Flintco, LLC
ATTN: Employee Services
1602 W. 21st Street
Tulsa, OK 74107-2708

When you call or write, be sure to have the 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.

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 Employee if you are a regular full-time employee of the Employer or a Participating Employer who works, on average, at least 30 hours per week or 130 hours per month.

The following individuals are not eligible for participation in the Plan unless it is determined that the individual works, on average, at least 30 hours per week or 130 hours per month: a part-time, temporary, seasonal (other than summer interns), contract, leased or project-based employee of the Employer or a Participating Employer, an individual covered by a collective bargaining agreement between the Employer or a Participating Employer and an employee representative (unless the agreement between the Employer or Participating Employer and the employee representative provides for coverage under the Plan); a non-resident alien who receives no income from the Employer or a Participating Employer that is considered income from sources in the United States; an individual paid through the payroll of a temporary agency or similar organization; an individual who has a written contract with the Employer or a Participating Employer stating either that the individual is not an employee or is not entitled to participate in the employee benefit plans of the Employer or Participating Employer; or an individual designated, compensated or otherwise treated as an independent contractor by the Employer or a Participating Employer.

The eligibility date for all benefits programs is the first day of the month following completion of 30 days of continuous full-time service for an Eligible Employee. An absence during the first 30 days due to any health factor will not be considered an interruption of the continuous service requirement.

To have coverage begin on your eligibility date, you must complete and submit the enrollment form within 31 days of your eligibility date. You will also have the opportunity during the Plan Annual Enrollment period each year to make a new or changed election for benefits effective June 1, subject to applicable restrictions under each benefits program.

Continuing Coverage During Certain Leaves of Absence

In certain instances, you and your dependents may be able to continue coverage under the Plan during your approved leave of absence. The Benefits Descriptions describe any state laws that may allow you to continue your coverage under the Plan during an approved leave of absence. In addition, special rules may

apply to leaves that qualify under the Family and Medical Leave Act of 1993 ("FMLA"). Your Participating Employer will tell you if your leave qualifies under the FMLA. See the "Family and Medical Leave Act" heading for a summary of the rules that may apply.

For an approved leave of absence that is a military leave, you and your dependents may be able to continue your coverage under the Plan beyond the time period(s) otherwise required by applicable state and/or federal laws. See the "Continuation of Coverage for Military Leave" heading for a summary of these rules.

WHO IS AN ELIGIBLE DEPENDENT

An Eligible Dependent is defined as an Employee's:

- spouse (as defined under federal tax law).

- child, including a newborn child, adopted child (or child place for adoption), step-child, grandchild or any other child for whom you or your spouse is legally responsible (such as a foster child) under age 26.

  — Unmarried Dependent children age 26 or over who are medically certified as disabled and dependent upon you or your spouse are eligible for coverage regardless of age.

  The Plan reserves the right to request verification of a Dependent's age, marital or other status as an Eligible Dependent upon initial enrollment and from time to time thereafter as the Plan may require.

HOW TO ENROLL

To Enroll in this health care program, you must complete an application form provided by the Plan, including all information needed to determine eligibility. Your membership may include:

- Member Only (Single) Coverage — if only you Enroll.
- Member, spouse and children Coverage (Family Coverage) — for you and all of your Eligible Dependents.

INITIAL ENROLLMENT PERIOD

- **Initial Enrollment**

  If you become an Eligible Person 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) is the first of the month following completion of your applicable Waiting Period as set forth in the Plan.

- **Initial Enrollment of New Dependents**

  You can apply to add Dependents to your coverage if we receive your "Family Status Change Form" within 31 days after you acquire an Eligible Dependent (see exceptions below for newborn children). The Effective Date for the Eligible Dependent will be the date the Dependent was acquired.

  — **Newborn Children**

If you have a newborn child while covered under this Summary, you may add coverage effective on the date of his or her birth. However, your "Family Status Form" must be received by the Plan within 31 days of the child's birth.

— **Adopted Children**

An adopted child or a child Placed for Adoption may be added to your coverage, provided your "Family Status Form" is received by the Plan within 31 days of 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 the Plan with the change form.

SPECIAL ENROLLMENT PERIODS

Your Plan includes Special Enrollment Periods during which individuals who previously declined coverage are allowed to Enroll (without having to wait until the Plan's next regular Annual 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. .

- **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 premiums on a timely basis, or for cause (such as making a fraudulent claim or an intentional

misrepresentation of a material fact in connection with the plan). "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 premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or any intentional misrepresentation of a material fact in connection with the plan).

— Your application for special enrollment must be received by the Plan within 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 to Enroll or your "Family Status Form" (if you are already enrolled) must be received by the Plan 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 no later than first day of the month after the date the request for enrollment is received.

— 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 Gaining or Losing Health Coverage State Assistance**

You may be able to enroll yourself and your dependents in the Plan later than your initial enrollment period if:

1. you or a dependent loses coverage under Medicaid or a state child health insurance program, or

2. you or a dependent becomes eligible for group health plan premium assistance under Medicaid or a state child health insurance program.

You must request enrollment in the Plan and file a completed enrollment form within 60 days of losing such other coverage or gaining premium assistance eligibility.

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

  The Plan must receive an enrollment application for an Eligible Dependent within 31 days after issuance of a court order requiring coverage be provided for a spouse or minor or Dependent child under the Member's coverage. The Effective Date will be determined by the Plan in accordance with the provisions of the court order.

ANNUAL ENROLLMENT PERIOD

If you do not Enroll for coverage for yourself or for your Eligible Dependent(s) during the Initial Enrollment Period or during a Special Enrollment Period, you may apply for coverage at any time. However, coverage will be delayed until the Plan's next Annual Enrollment unless you experience a status change event for which an election change is allowed under the Flexible Benefit Plan. In order to verify your coverage election, you and/or your Dependent(s) will be asked to "reapply" for coverage during the Plan's Annual Enrollment Period. An Annual Enrollment Period will be held prior to the beginning of each Plan Year. Your application for coverage must be received by the Plan within this time period.

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;
- the child's date of birth and Social Security Number;
- a reasonable description of the type of coverage to be provided to the child or the manner by which the coverage is to be determined;
- the period to which the order applies; and
- each group health plan to which the order applies.

To be a qualified order, the order cannot require the Plan to provide any type or form of Benefits or any option not otherwise provided by the Plan, except as otherwise required by law. You will be responsible for paying all applicable premium contributions, and any 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 Employee Services at (918) 587-8451.

DELAYED EFFECTIVE DATE

If you apply for coverage and are not Actively at Work on what would be your Effective Date, then the Effective Date will be delayed until the date you are Actively at Work. This provision will not apply if you were absent from work due to a health status factor.

DELETING A DEPENDENT

When certain life events occur as outlined in your Employer's cafeteria plan document, you may be able to change your coverage to delete a Dependent. The change will be effective at the end of the month in which the Dependent's eligibility ceases. Contact your Employer for more information on whether you may make this kind of change.

COBRA CONTINUATION COVERAGE

- **Eligibility for Continuation Coverage**

  When a Qualifying Event occurs, eligibility under this Summary 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 your Plan's coverage 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 premiums 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.

- **Other Coverage Options Besides COBRA**

Instead of enrolling in COBRA continuation coverage, there may be other coverage options available to you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. To learn more about enrolling in the Health Insurance Marketplace visit www.healthcare.gov.

- **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.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

Coverage during a FMLA leave of absence will be administered in accordance with the policies established by the Employer and applicable law, including the following:

- during an FMLA leave of absence, coverage under this Plan shall be maintained on the same terms and conditions as the coverage that would have been provided if the covered Employee had not taken the FMLA leave (including any Employee contribution requirement); and
- if Plan coverage lapses during the FMLA leave, coverage will be reinstated upon the Employee's return to work at the conclusion of the FMLA leave, but only for the person(s) who had coverage under the Plan when the FMLA leave began.

It is the intention of the Employer to provide FMLA benefits only to the extent required by applicable law and not to confer greater rights than those required by law on any covered person.

CONTINUATION OF COVERAGE FOR MILITARY LEAVE

- **Introduction**

  In addition to COBRA rights, a Covered Person may be entitled to continue coverage under the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended ("USERRA"). USERRA requires your Employer to offer Employees and their families the opportunity to pay for a temporary extension of health coverage (called "USERRA continuation coverage") at group rates where health coverage under Employer-sponsored group health plan(s) would otherwise end because of the Employee's service in the uniformed services (e.g., for service in the military).

  This section is intended to inform Covered Persons, in summary fashion, of their rights and obligations under the continuation coverage provision of USERRA. It is intended that no greater rights be provided than those required by this law. It does not fully describe your USERRA continuation coverage rights. For additional information about your rights and obligations under the Plan and under federal law, you should contact the Plan Administrator,

- **Service Leave Event**

  If covered under this Plan, the Employee has the right to elect USERRA continuation coverage for him/herself, his/her spouse, and his/her Dependents if they lose coverage under this Plan due to an absence from employment for service in the uniformed services (a "service leave").

- **Service in the Uniformed Service**

  Service in the uniformed services generally means the voluntary or involuntary performance of duties in the uniformed services. The uniformed services include the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty for training, or full-time National Guard duty, the corps of the Public Health Service, and the National Disaster Medical

System when providing services as an intermittent disaster response appointee following federal activation or attending authorized training in support of its mission.

- **Election Rights**

You have sixty (60) days to elect USERRA continuation coverage, measured from the date your absence from employment for the purpose of performing service begins. If USERRA continuation coverage is elected within this period, the coverage is retroactive to the date coverage would otherwise have been lost. If USERRA continuation coverage is not elected within this period, coverage under the Plan ends.

- **Type of Coverage, Maximum Period and Cost**

Initially, the coverage will be the same coverage as immediately preceding your service leave. Thereafter, coverage will be the same as the coverage provided to similarly situated Employees or Dependents that are not on service leave.

The law requires that you generally be allowed to maintain USERRA continuation coverage for a twenty-four (24) month period beginning on the date of your absence from employment for the purpose of performing service begins.

A person electing USERRA continuation coverage may be required to pay all or part of the cost of USERRA continuation coverage. If you perform service in the uniformed services for fewer than thirty-one (31) days, you will pay the same amount for the coverage that you normally pay. If your service exceeds thirty (30) days, the amount charged cannot exceed 102% of the cost to the Plan of providing the coverage. Payment is generally due monthly on the first day of the month. Payment is considered "made" on the date sent. You will be given a grace period of 30 days within which to make the payment.

- **Termination of USERRA Continuation Coverage**

The USERRA continuation coverage may be terminated before the end of the maximum continuation period for any of the following reasons:

- the Employer no longer provides group health coverage to any of its Employees;
- the premium for USERRA continuation coverage is not paid on time (including the grace period);
- your failure to return from service or apply for a position of employment as required under USERRA; or
- termination for cause under the generally applicable terms of this Plan (e.g., submission of fraudulent benefit claims).

WHEN COVERAGE UNDER THIS SUMMARY ENDS

When a Covered Person is no longer an Eligible Person or Eligible Dependent, coverage stops at the end of the month in which eligibility ceases, except in the following cases:

- A Covered Person's COBRA Continuation Coverage, when applicable, will cease on 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 Plan stops providing any Benefits to any Employee;

- — the date on which coverage stops because of a Covered Person's failure to pay to the Plan any premiums 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; 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 or the Plan commits 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 premiums are not paid, your coverage will stop at the end of the coverage period for which your premiums have been paid.

- Termination of the Plan automatically ends all of your coverage at the same time and date. It is the responsibility of your Plan to tell you of such termination.

Medical Benefits Summary
Comprehensive Health Care Services

This section shows how much we pay 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.**

	CLUB		SPADE		DIAMOND		GENERAL PLAN LIMITS
	PPO IN NETWORK	OUT-OF-NETWORK	PPO IN NETWORK	OUT-OF-NETWORK	PPO IN NETWORK	OUT-OF-NETWORK	
Deductibles							Deductible applies unless noted. Deductible is waived for Benefits listed as payable at 100%.
Per Individual per Plan Year	$750	$1,500	$1,500	$3,000	$3,000	$6,000	Blue Preferred PPO and Out-of-Network do not apply to each other.
Per Family per Plan Year	$1,500	$3,000	$3,000	$6,000	$6,000	$12,000	Blue Preferred PPO and Out-of-Network do not apply to each other. **Not Included in deductibles**: Blue Preferred PPO office visit copayments, prescription drug copayments, precertification penalties, ER copayments, charges in excess of plan maximums, excess charges over the allowable charge, benefit exclusions.
Coinsurance	80%	50%	80%	50%	80%	50%	In Network coinsurance applies after deductible is met. No coinsurance after out-of-pocket maximum satisfied

	CLUB		SPADE		DIAMOND		GENERAL PLAN LIMITS
	PPO IN NETWORK	OUT-OF-NETWORK	PPO IN NETWORK	OUT-OF-NETWORK	PPO IN NETWORK	OUT-OF-NETWORK	
Copayments							
Office Visit, Preventive Care	No co-pay	Deductible & Co-insurance of 50%	No co-pay	Deductible & Co-insurance of 50%	No Deductible	Deductible & Co-insurance of 50%	
Office Visit, Primary Care	$20.00	Deductible & Co-insurance of 50%	$30.00	Deductible & Co-insurance of 50%	Deductible & Co-insurance of 80%	Deductible & Co-insurance of 50%	
Office Visit, Specialist	$40.00	Deductible & Co-insurance of 50%	$50.00	Deductible & Co-insurance of 50%	Deductible & Co-insurance of 80%	Deductible & Co-insurance of 50%	
Emergency Room	$250 co-pay, then deductible and 20% co-insurance	$250 co-pay, then deductible and 20% co-insurance	$250 co-pay, then deductible and 20% co-insurance	$250 co-pay, then deductible and 20% co-insurance	Deductible & Co-insurance of 20%	Deductible & Co-insurance of 20%	Emergency room copay waived if admitted
Out-of-Pocket Maximums	In network annual deductible & co-pays are included		In network annual deductible & co-pays are included		In network annual deductible is included		**Included:** 20%-50% Coinsurance; copayments.
Per Individual per Plan Year	$3,500	$7,000	$5,250	$9,750	$6,000	$12,000	**Not Included in Out-of-Pocket:** Precertification penalties, excluded services, charges in excess of Plan maximums and excess amount over the allowable charge.
Per Family per Plan Year	$7,000	$14,000	$10,500	$19,500	$12,000	$24,000	Blue Preferred PPO and Out-of-Network do not apply to each other.
Organ and Tissue Transplants Travel and Lodging Combined Maximum							Travel and lodging limited to $5,000 per transplant
Smoking Cessation – See Rx Summary							Limited to one (1) intervention per year

OUT-OF-NETWORK PLACE OF SERVICE LIMITATIONS

It is important to utilize Blue Preferred PPO Providers to receive the highest level of benefits. When services are performed at an Out-of-Network facility or by a provider they are not required to write off what BCBSOK considers to be the allowable. Please see example of balance billing that can take place when services are outside the network.
There are few exceptions in which a member can receive in network level of benefits at billed charges as listed below.

- If a PPO Physician or PPO facility refers x-ray and/or laboratory services to an Out-of-Network Provider, those services will be considered at the PPO level of benefits.

- If no PPO providers within 50 miles of the service area, benefits will be considered at the PPO level of benefits.

Definition of Medical Emergency:

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

- serious jeopardy to the Subscriber's health;

- serious impairment to bodily function; or

- serious dysfunction of any bodily organ or part.

Individuals who are referred outside the PPO Network by a PPO Physician will be considered at the Out-of-Network level of benefits.

Example of Balance Billing that could occur when Services are Received from Out-of-Network (OON) Provider (Assuming Benefit Period Deductible has been Satisfied)

Provider Charge:	$5,000
BCBSOK PPO Allowable:	$2,000 – OON Provider does not have to accept allowable
BCBSOK Payment 50% for Out-of-Network:	$1,000
Member Share 50% for Out-of-Network:	$1,000
Total Provider can bill Member:	$4,000 – Provider is billing for difference between provider charge and allowable $3,000 and the member share 50% of $1,000 for a total of $4,000.

BENEFIT PERCENTAGE

The following chart shows the percentage of Allowable Charges covered by your Blue Preferred PPO program through payments and/or contractual arrangements with Providers. **These percentages apply only after your Deductible and/or Copayment, as applicable, has been satisfied**.

BENEFIT	BCBSOK PPO	OON	COMMENTS
Allergy Injections/Serum	100% After copay	50%	If there is an Office Visit billed with the allergy injection/serum, then there will be an office visit copayment for In-Network Services
Allergy Testing	80%	50%	
Ambulance Services Ground and Air Transportation	80%	80%	See the Ambulance section for out of network emergency appeal process.
Ambulatory Surgery Facility Charges	80%	50%	
Anesthesia Inpatient and Outpatient	80%	50%	
Audiological Services	80%	50%	One Hearing Aide per ear every 48 months; and up to four (4) additional ear molds per plan year for covered persons up to two years of age. Must be prescribed by a licensed audiologist.
Bariatric Weight Loss	80%	80%	
Birthing Centers	80%	50%	
Bone Density (Osteoporosis) Screening[1]	100%	50%	
Chemotherapy	80%	50%	
Chiropractic Care	80%	50%	Subject to Office Visit Copayment for In-Network Services. Limited to a Plan Year Maximum of $750.
Colonoscopy / Colorectal Screening[1]	100%	50%	One per Plan Year (routine or diagnostic)
Convalescent Care (Inpatient Rehab Care)[2]	80%	50%	Limited to 90 days per Plan Year $500 penalty applies for non-precertification

[1] Preventive Care – subject to age and frequency guidelines. No cost to Participant when using In-Network Provider (BCBSOK PPO).

[2] Hospital Precertification is required. Emergency or urgent admissions must be pre-certified within 2 days of admission. Please refer to *Precertification* section in this Summary Plan Description for details. Admissions can be pre-certified by calling the Precertification Area 1-800-672-2378.

BENEFIT	BCBSOK PPO	OON	COMMENTS
Drug and Alcohol Related Services	80%	50%	$500 penalty applies for non-precertification $200 copayment applies for Out-of-Network admissions
Inpatient Room & Board Inpatient Miscellaneous[2]	80%	50%	
Inpatient Provider Visits	80%	50%	
Provider Office Visits	100% after copay	50%	Office visit copayment applies to PPO office visits.
Durable Medical Equipment	80%	50%	
Flu Shots including Flu Mist Regardless of Diagnosis[1]	100%	50%	
Gynecological Exam and Pap Smear[1]	100%	50%	One per Plan Year
Home Health Care	80%	50%	Limited to 120 Visits per Plan Year. $500 penalty applies for non-precertification
Hospice Inpatient and Outpatient	80%	50%	
Hospital Benefits Inpatient[2] Inpatient Room & Board Inpatient Miscellaneous Inpatient Physician Visits Hospital Pre-Admission Testing	80%	50%	$500 penalty applies for non-precertification. $200 copayment applies for Out-of-Network admissions
Hospital Outpatient Services	80%	50%	
Hospital Emergency Room	100%	100%	$250 ER Copayment or Deductible applies for In-Network and Out-of-Network Services. Copayments are waived if admitted to the Hospital
Immunizations (Adult and Child)[1]	100%	50%	
Infertility Service Expenses	80%	50%	Applies to the diagnosis for infertility only.
Mammograms[1]	100%	50%	Limited to one per year (routine or diagnostic). Deductible and Coinsurance applies for additional services.
Maternity Expenses	80%	50%	Midwives only covered when done in all settings except the home
Medical Supplies	80%	50%	

[1] Preventive Care – subject to age and frequency guidelines. No cost to Participant when using In-Network Provider (BCBSOK PPO).

[2] Hospital Precertification is required. Emergency or urgent admissions must be pre-certified within 2 days of admission. Please refer to *Precertification* section in this Summary Plan Description for details. Admissions can be pre-certified by calling the Precertification Area 1-800-672-2378.

BENEFIT	BCBSOK PPO	OON	COMMENTS
Mental and Nervous Related Services	80%	50%	$500 penalty applies for non-precertification
Inpatient Room & Board[2]	80%	50%	
Inpatient Miscellaneous[2]	80%	50%	
Inpatient Provider Visits	80%	50%	
Outpatient Provider Office Visits	100% after copay	50%	Office Visit Copayment applies for Blue Preferred PPO and BlueCard PPO providers
Autism	100% after copay	50%	
Newborn Charges	80%	50%	Newborn charges considered as a dependent child
Occupational Therapy	80%	50%	Limited to 60 days per Plan Year
Organ and Tissue Transplants	80%	50%	
Travel and Lodging	80%	50%	Travel and lodging limited to $5,000 combined per Transplant
Orthotics	80%	50%	Custom Foot Orthotics are covered for diabetic's shoes only
Outpatient Diagnostic X-ray and Lab	100%	50%	Subject to Deductible
Except: MRI, CAT Scans, PET Scans and Diagnostic Medical procedures	80%	50%	Subject to Deductible and Coinsurance level for In and Out of Network
Physician Office Visits	100% after copay	50%	Office visit copayment applies when office services are billed for a Blue Preferred PPO and Blue Card PPO office visit. One office visit copayment applies per day regardless the number of visits.
Not included: Allergy Testing, MRI, PET Scan, CT Scan, Physical Therapy, Occupational Therapy, Speech Therapy, Chemotherapy, Orthotics, Prosthetics, Durable Medical Equipment	80%	50%	
In Office Surgery	100%	50%	Office Visit Copayment applies for Blue Preferred and BlueCard PPO Office Visit
Diagnostic Lab and X-ray in office Well Child Visit[1]	100%	50%	

[1] Preventive Care – subject to age and frequency guidelines. No cost to Participant when using In-Network Provider (BCBSOK PPO).

[2] Hospital Precertification is required. Emergency or urgent admissions must be pre-certified within 2 days of admission. Please refer to *Precertification* section in this Summary Plan Description for details. Admissions can be pre-certified by calling the Precertification Area 1-800-672-2378.

BENEFIT	BCBSOK PPO	OON	COMMENTS
Physical Therapy	80%	50%	Limited to 60 Visits per Plan Year
Preventive Services[1]	100%	50%	Refer to list under "Preventive Services
Podiatry Benefits	80%	50%	
Prostate Test and Digital Rectal Examinations[1]	100%	50%	
Private Duty Nursing Care Inpatient/Outpatient	80%	50%	Limited to $25,000 per Plan Year, for care that enables your condition to improve.
Prosthetic Appliances	80%	50%	
Radiation Therapy	80%	50%	
Skilled Nursing Facility/Extended Care Facility	80%	50%	$500 penalty applies for non-precertification
Speech Therapy	80%	50%	Limited to 60 Visits per Plan Year
Surgery Inpatient/Outpatient	80%	50%	
Urgent Care Facility	80%	50%	Office Visit Copayment applies for In Network Only

[1] Preventive Care – subject to age and frequency guidelines. No cost to Participant when using In-Network Provider (BCBSOK PPO).

[2] Hospital Precertification is required. Emergency or urgent admissions must be pre-certified within 2 days of admission. Please refer to *Precertification* section in this Summary Plan Description for details. Admissions can be pre-certified by calling the Precertification Area 1-800-672-2378.

Prescription Drug Benefit Summary

Flintco, LLC
RxBenefits / Optum Group Number: Flintco
Effective Date: June 1, 2020

PRESCRIPTION DRUG BENEFITS	PPO IN NETWORK CLUB PLAN	PPO IN NETWORK SPADE PLAN	HDHP IN NETWORK DIAMOND PLAN	GENERAL PLAN LIMITS
30-Day Supply				
Over the Counter (OTC)	No Copay	No Copay	Deductible and Co-Insurance	Must have physician's written prescription
Contraceptive Drugs	No Copay	No Copay	Deductible and Co-Insurance	FDA-approved prescription oral contraception methods prescribed for women
Generic	$10 Copay	$15 Copay	Deductible and Co-Insurance	Limited to the lesser of the prescription number of days written or 30-day supply.
Formulary Brand Name[1]	$35 Copay	$45 Copay	Deductible and Co-Insurance	
Non-Formulary Brand Name	$50 Copay	$70 Copay	Deductible and Co-Insurance	
Specialty Drug	$75 Copay	$100 Copay	Deductible and Co-Insurance	Must be filled by RxBenefits / Optum / Briova Specialty Pharmacy (contact customer service)
90-Day Supply[2]				
Contraceptive Drugs	No Copay	No Copay	Deductible and Co-Insurance	FDA-approved prescription oral contraception methods prescribed for women
Generic	$20 Copay	$30 Copay	Deductible and Co-Insurance	Applies to retail pharmacy or mail order home delivery.
Formulary Brand Name	$70 Copay	$90 Copay	Deductible and Co-Insurance	
Non-Formulary Brand Name	$100 Copay	$100 Copay	Deductible and Co-Insurance	
Specialty Drug	N/A	$140 Copay	Deductible and Co-Insurance	Must be filled by RxBenefits / Optum / Briova Specialty Pharmacy (contact customer service)
Tobacco Prescription Drug Therapy				Limited to one (1) course of treatment per Plan year

Must be filled by RxBenefits / Optum / Briova Specialty Pharmacy (contact customer service)

Customer Service	1-800-334-8134
Help Desk	1-800-880-1188
Mail Fax Refill Service	1-800-881-1889
BriovaRx Specialty Pharmacy	1-855-427-4682

[1] This program dispenses a Generic Prescription Drug whenever possible. If you elect a Brand Name Drug when a generic is available, you are required to pay the "Copayment" plus the cost difference, unless the Physician specifies name brand only on prescription.

[2] Some medications are limited to a 30-day supply by the Federal Drug Administration and/or RxBenefits / Optum and require a new prescription for each 30-day supply. Mail order prescriptions, for "maintenance" and "non-maintenance" medications, should be written for 90-day quantities when possible and appropriate.

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

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;

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

  Inpatient services are subject to the Precertification guidelines of this Plan (see *"Important Information"*). If you fail to comply with these guidelines, Benefits for covered Medical Expenses 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;

  — Blood, charges for blood transfusions, including the cost of whole blood and blood plasma if the blood was not donated or replaced in the operation of a blood bank.

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

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

  — Oxygen, charges for oxygen and the equipment for its use and administration;

  — 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**

  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.

- **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 this 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 this Plan; and
    - a separate Deductible will apply to the newborn's Hospital Confinement.

SURGICAL/MEDICAL SERVICES

The Plan pays the scheduled amounts for the following covered Medical Expenses you receive from a Physician or other Provider.

- **Acupuncture**

  Charges for acupuncture if performed by a Physician as a form of anesthesia in connection with a covered surgery.

- **AIDS**

  Treatment of Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV).

- **Allergy**

  Charges for allergy testing, serum, and injections.

- **Surgical Benefits**

  Surgical Benefits include professional fees for performing any Medically Necessary Surgical Procedure in or out of the Hospital to treat Illness or Injury. Surgical Benefits include manual and operative procedures including, but not limited to, the repair of Injuries, correction of deformities and defects, diagnosis and cure of certain diseases, and those procedures normally considered as surgical. Normal pre-operative and post-operative care is included in the allowance for the Surgical Procedure.

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.

- **Bariatric Surgery and Lap Band**

Services related to bariatric surgery, including post-surgical panniculectomy for any Covered Person.. Benefits are provided only for Covered Services rendered by Blue Preferred PPO or BlueCard PPO Providers and only when the Covered Person has satisfied each of the following requirements:

— The Covered Person must have a diagnosis of "Morbid Obesity," defined as:

  - Body Mass Index (BMI) of greater than or equal to 40 kg/meters squared; or
  - BMI greater than or equal to 35 kg/meters squared with at least two of the following co-morbid conditions which have not responded to maximum medical management and which are generally expected to be reversed or improved by bariatric treatment:
    - Hypertension;
    - Dyslipidemia;
    - Diabetes Mellitus;
    - Coronary heart disease; and/or
    - Sleep apnea.

— The Covered Person must have completed an appropriate non-surgical weight loss treatment program prior to undergoing surgical treatment for obesity. In order to be considered "appropriate" treatment, the following criteria must be met:

  - The Covered Person must provide medical records documenting active participation in a clinically-supervised, non-surgical program of weight reduction for at least six months, occurring prior to the proposed surgery and preferably unaffiliated with the bariatric surgery program. (NOTE: The initial BMI at the beginning of a weight reduction program will be the "qualifying" BMI used to meet the BMI criteria for the definition of Morbid Obesity used in this amendment.)

**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.*

- A program will be considered appropriate if it includes the following components:
  - Nutritional therapy, which may include medical nutrition therapy such as a very low calorie diet such as MediFast or OptiFast, or a recognized commercial diet-based weight loss program such as Weight Watchers, Jenny Craig, etc.;
  - Behavior modification or behavioral health interventions;
  - Counseling and instruction on exercise and increased physical activity; and
  - Ongoing support for lifestyle changes to make and maintain appropriate choices that will reduce health risk factors and improve overall health.

Benefits will not be provided for non-surgical weight loss treatment programs.

Benefits are not provided for any services which the Plan determines are Experimental/Investigational/Unproven.

- **Sterilization** - Charges for tubal ligations and vasectomies, but not the reversal of the procedures.

- **Assistant Surgeon**

  Services of a Physician who actively assists the operating surgeon in the performance of covered Surgery.

- **Anesthesia**

  Anesthesia charges when performed in conjunction with a covered Surgical Procedure if the anesthetic is administered by a Physician other than the operating or assistant surgeon, a Certified Registered Graduate Nurse Anesthesiologist (CRNA), or any other qualified Provider of service that is allowed by the state where the Surgery is performed.

- **Inpatient Medical Services**

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

  — Inpatient Medical Care Visits

  Inpatient Medical Care visits are limited to 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

Charges for Medically Necessary expenses Incurred by a newborn infant during their initial confinement, including services and supplies furnished by a Hospital to care for the newborn infant during initial Hospital Confinement. Inpatient Physician care includes Physician visits and the circumcision of a male infant.

Inpatient Hospital and related expenses Incurred for care of a newborn will be considered under the newborn's benefit record, and will be subject to separate Deductible and Coinsurance applicable for the new Dependent.

- **Outpatient Medical Services**

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

— Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder/Autism

Testing and diagnosis of Attention Deficit Disorder (ADD), Attention Deficit Hyperactivity Disorder (ADHD) and Autism.

— Audiological Services

Audiological services and hearing aids, limited to:

- **One hearing aid per ear every 48 months; and**
- **Up to four additional ear molds per Plan Year for Covered Persons up to two years of age.**

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

— **Blood**

Charges for blood transfusions, including the cost of whole blood and blood plasma if the blood was not donated or replaced in the operation of a blood bank.

— **Cardiac Rehabilitation** - Charges for Cardiac Rehabilitation, provided the services meet the following qualifications:

- Under the supervision of a Physician;
- In connection with a myocardial infarction, coronary occlusion, or coronary bypass Surgery;
- Initiated within 12 weeks after other treatment for the medical condition ends.

— **Chiropractic/Spinal Manipulation**

Charges for chiropractic and/or spinal manipulation services and related modalities by a licensed M.D., D.O., or D.C., as specified in the ***MEDICAL BENEFITS SUMMARY***.

- $750 Plan Year Maximum Applies
- Lab and X-ray billed by a Chiropractor are not subject to the Plan Year Maximum
- If a Chiropractor renders Physical Therapy services the service will be applied to the Chiropractor maximum instead of the Physical Therapy Maximum. If the Muscle/Spinal Manipulations are billed by a provider other than a Chiropractor, they will be applied to the Physical Therapy Maximum.

— **Contraceptive Drug Benefit**

Charges for prescription oral, injectable and implantable contraceptive devices. Prescription oral contraceptives are covered under the Prescription Drug portion of the Plan.

— **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;
  - 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 re-education or refresher training is Medically Necessary.

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

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

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

— **Drugs and Medications**

Charges for drugs and medications (including insulin) prescribed by a Physician and dispensed by a licensed pharmacist, which are necessary for the treatment of an Injury or Illness.

— **Emergency Accident Care**

Treatment of Accidental bodily Injuries.

— **Emergency Medical Care**

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

— **Emergency Room/Urgent Care Facility**

Charges for Medically Necessary services and supplies furnished by the emergency department of a Hospital, or an Urgent Care Facility.

— **Eyeglasses**

Charges for the initial pair of contacts or eyeglasses following cataract Surgery.

— **Immunizations**

Limited to all recommended immunizations (with a Grade A or B) for children and adults.

— **Infertility**

Treatment is only covered up to the diagnosis of infertility only.

— **Medical Supplies**

Charges for medical supplies that are prescribed by a Physician and Medically Necessary, including, but not limited to, splints, casts, and slings.

— **Prescription Drugs**

Prescription Drug Benefits are considered for drugs, which under Federal Law, are only obtainable with a Physician's Prescription Order and distributed by a licensed pharmacist. Prescription Drugs are subject to the Deductible and Coinsurance or Copayment specified in the ***MEDICAL BENEFIT SUMMARY***. Please also refer to ***PRESCRIPTION DRUG BENEFITS SUMMARY***.

When new Prescription Drugs are manufactured and become available for public use, they will be considered under the Plan only if:

- The drug is approved by the Food and Drug Administration;
- The drug is not considered Experimental/Investigational/Unproven; and
- The drug is not otherwise excluded by the Plan or Prescription Drug Program.

— **Reconstructive Surgery**

Charges for reconstructive Surgery when the Surgery is necessary for treatment by a Physician to correct a condition resulting from an Accident or treatment of a congenital condition for a Dependent Child.

— **Well Child Care Services**

The periodic review of a child's physical and emotional status by a Physician or other Provider pursuant to a Physician's supervision, including a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory test in keeping with prevailing medical standards and as required under the Affordable Care Act.

Well Child Care Services must be rendered during a periodic review, provided by or under the supervision of a single Physician during the course of one visit. Charges for routine physical examinations and diagnostic tests performed as part of the examination are covered as specified in the ***Medical Benefit Summary.***

— **Sleep Disorders**

Care and treatment for sleep disorders if deemed Medically Necessary.

— **Tobacco Prescription Drug Therapy**

Charges for legend smoking cessation products purchased through the Informed Rx Prescription Drug Program, up to the limits specified in the ***PRESCRIPTION DRUG BENEFIT SUMMARY***.

— **Vitamins**

Vitamins that require a prescription, including, but not limited to pre-natal vitamins.

OUTPATIENT DIAGNOSTIC SERVICES

Charges for Outpatient diagnostic x-ray and laboratory services that are provided for or recommended by a Physician. The diagnostic x-ray and/or laboratory examinations may be performed in the Physician's office, the Outpatient department of a Hospital, or in a free-standing x-ray or laboratory facility.

Routine pap smears and routine mammograms will be considered as part of the Preventive Services Benefit. Pap smears and mammograms associated with a medical diagnosis will be considered under the Outpatient Diagnostic Services Benefit. Please refer to the ***MEDICAL BENEFIT SUMMARY*** for details.

Services performed for the express purpose of determining the cause of definite symptoms experienced by the patient. Covered Expenses include:

- Radiology, Ultrasound and Nuclear Medicine.
- Laboratory and Pathology.
- Magnetic resonance imaging (MRI);
- Computed tomography (CT);
- ECG, EEG, and Other Electronic Diagnostic Medical Procedures and Physiological Medical Testing, as determined by the Claims Administrator.

OUTPATIENT THERAPY SERVICES

- Radiation Therapy - Charges for Medically Necessary Radiation Therapy;
- Chemotherapy - Charges for Medically Necessary Chemotherapy;
- Respiratory Therapy;
- Dialysis Treatment - Charges for kidney dialysis and related services;

- Physical Therapy - Physical Therapy provided by a licensed physical therapist. Physical Therapy must be ordered by a Physician, result from an Illness or Injury, and improve a body function. Physical Therapy must be in accordance with the Physician's exact orders as to type, frequency, and duration. **Benefits are limited to 60 visits per Plan Year.**

- Occupational Therapy - Charges for Occupational Therapy provided by a licensed occupational therapist. Occupational Therapy must be ordered by a Physician, result from an Illness or Injury, and improve a body function. Occupational Therapy must be in accordance with the Physician's exact orders as to type, frequency, and duration. **Benefits are limited to 60 visits per Plan Year.**

- Speech Therapy by a qualified speech therapist that meets the following criteria:

  — Speech Therapy to restore speech after a loss or impairment of a demonstrated previous ability to speak; or

  — Speech Therapy to develop or improve speech after Surgery to correct a defect that both:

    - existed at birth; and

    - impaired, or would have impaired the ability to speak.

Speech Therapy Maximum is limited to 60 Visits Per Plan Year

PREVENTIVE SERVICES

Services are limited to one per year unless more restrictive guidelines are recommended by the U.S. Preventive Service Task Force or reflected in the Center for Disease Control's immunization guidelines. An office visit that is not billed separately from the preventive service and is for the primary purpose of receiving preventive services is also covered at 100% (with no copay).

— **Covered Preventive Services for Adults**

- **Abdominal Aortic Aneurysm** one-time screening for men of specified ages who have ever smoked
- **Alcohol Misuse** screening and counseling
- **Aspirin** use for men and women of certain ages
- **Blood Pressure** screening for all adults
- **Cholesterol** screening for adults of certain ages or at higher risk
- **Colorectal Cancer** screening for adults over 50
- **Depression** screening for adults
- **Type 2 Diabetes** screening for adults with high blood pressure
- **Diet** counseling for adults at higher risk for chronic disease
- **HIV** screening for all adults at higher risk
- **Immunization** vaccines for adults--doses, recommended ages, and recommended populations vary:
  - Hepatitis A
  - Hepatitis B
  - Herpes Zoster
  - Human Papillomavirus
  - Influenza

  - Measles, Mumps, Rubella
  - Meningococcal
  - Pneumococcal
  - RSV
  - Tetanus, Diphtheria, Pertussis
  - Varicella
- **Obesity** screening and counseling for all adults
- **Prostate Cancer** routine/medical screening for the early detection of prostate cancer in male Covered Persons including a prostate-specific antigen (PSA) blood test and a digital rectal examination
- **Routine Physical** for adults covered one time per Plan Year.
- **Sexually Transmitted Infection (STI)** prevention counseling for adults at higher risk
- **Syphilis** screening for all adults at higher risk
- **Tobacco Use** screening for all adults and cessation interventions for tobacco users
- Vitamin D screening for individuals age 65 and over who are at increased risk for falls

— **Covered Preventive Services for Women, Including Pregnant Women**

- **Anemia** screening on a routine basis for pregnant women
- **Bacteriuria** urinary tract or other infection screening for pregnant women
- **BRCA** counseling about genetic testing for women at higher risk
- **Breast Cancer Mammography** screenings every 1 to 2 years for women over 40
- **Breast Cancer Chemoprevention** counseling for women at higher risk
- **Breast Feeding** support supplies and counseling
- **Cervical Cancer** screening for sexually active women
- **Chlamydia Infection** screening for younger women and other women at higher risk
- **Contraception:** Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs
- **Domestic and Interpersonal Violence** screening and counseling for all women
- **Folic Acid** supplements for women who may become pregnant
- **Gestational Diabetes** screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
- **Gonorrhea** screening for all women at higher risk
- **Hepatitis B** screening for pregnant women at their first prenatal visit
- **HIV** screening and counseling for all women
- **HPV:** high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older
- **Osteoporosis** screening for women over age 65 depending on risk factors
- **Routine Gynecological Examination**
- **Rh Incompatibility** screening for all pregnant women and follow-up testing for women at higher risk
- **STI**
- **Syphilis** screening for all pregnant women or other women at increased risk
- **Tobacco Use** screening and interventions for all women, and expanded counseling for pregnant tobacco users

— **Covered Preventive Services for Children**

- **Alcohol and Drug Use** assessments for adolescents

- **Autism** screening for children at 18 and 24 months
- **Behavioral** assessments for children of all ages
- **Blood Pressure** screening for children
- **Cervical Dysplasia** screening for sexually active females
- **Congenital Hypothyroidism** screening for newborns
- **Depression** screening for adolescents
- **Developmental** screening for children under age 3, and surveillance throughout childhood
- **Dyslipidemia** screening for children at higher risk of lipid disorders
- **Fluoride Chemoprevention** supplements for children without fluoride in their water source
- **Gonorrhea** preventive medication for the eyes of all newborns
- **Hearing** screening for all newborns
- **Height, Weight and Body Mass Index** measurements for children
- **Hematocrit or Hemoglobin** screening for children
- **Hemoglobinopathies** or sickle cell screening for newborns
- **HIV** screening for adolescents at higher risk
- **Immunization** vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary:
  - Diphtheria, Tetanus, Pertussis
  - Haemophilus influenza type b
  - Hepatitis A
  - Hepatitis B
  - Human Papillomavirus
  - Inactivated Poliovirus
  - Influenza
  - Measles, Mumps, Rubella
  - Meningococcal
  - Pneumococcal
  - Rotavirus
  - Varicella
- **Iron** supplements for children ages 6 to 12 months at risk for anemia
- **Lead** screening for children at risk of exposure
- **Medical History** for all children throughout development
- **Obesity** screening and counseling
- **Oral Health** risk assessment for young children
- **Phenylketonuria (PKU)** screening for this genetic disorder in newborns
- **Sexually Transmitted Infection (STI)** prevention counseling for adolescents at higher risk
- **Tuberculin** testing for children at higher risk of tuberculosis
- **Vision** screening for all children

MATERNITY SERVICES

This Plan complies with all provisions of the Newborns' and Mothers' Health Protection Act of 1996.

- Hospital Services and Surgical/Medical Services from a Provider (including the services of midwives in a facility setting only and do not provide services in the home) to a covered Employee or an Employee's covered Dependent for:

  — Normal Pregnancy;

  — Complications of Pregnancy;

— Interruptions of Pregnancy

  - Miscarriage.

  - Abortion if induced termination of a pregnancy by an acceptable means is medically indicated to safeguard the life of the mother.

- Covered Maternity Services include the following:

  — A minimum of 48 hours of Inpatient care at a Hospital, or a Birthing Center licensed as a Hospital, following a vaginal delivery for the mother and newborn infant who are covered under this 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 this Plan after childbirth, except as otherwise provided in this section; and

  — Postpartum home care following a vaginal delivery if childbirth occurs at home or in a Birthing Center licensed as a Birthing Center. The coverage shall provide for one home visit within 48 hours of childbirth by a licensed health care Provider whose scope of practice includes providing postpartum care. The visits shall include, at a minimum:

    - physical assessment of the mother and newborn infant;

    - parent education regarding childhood immunizations;

    - training or assistance with breast or bottle feeding; and

    - performance of any Medically Necessary and appropriate clinical tests.

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

- Inpatient care shall include, at a minimum:

  — physical assessment of the mother and newborn infant;
  — parent education regarding childhood immunizations;

  — training or assistance with breast or bottle feeding; and

  — performance of any Medically Necessary and appropriate clinical tests.

- The Plan may provide coverage for a shorter length of Hospital Inpatient stay for services related to maternity/obstetrical and newborn infant care provided:

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

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

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

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

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 MASTECTOMY AND RECONSTRUCTIVE SURGICAL SERVICES

This Plan complies with all provisions of the Women's Health and Cancer Rights Act of 1998.

On October 21, 1998, the Women's Health and Cancer Rights Act (WHCRA) was signed into law. WHCRA contains protections for patients who elect breast reconstruction in conjunction with a mastectomy. According to WHCRA, a group health plan that provides medical and surgical Benefits with respect to a mastectomy will provide, in a case of a Participant or beneficiary who is receiving Benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for the following:

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

- Inpatient Hospital Services for:

— not less than 48 hours of Inpatient care following a mastectomy; and

— not less than 24 hours of Inpatient care following a lymph node dissection for the treatment of breast cancer.

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

- Coverage for reconstructive breast Surgery performed as a result of a partial or total mastectomy. Covered Services shall consist of the following, when provided in a manner determined in consultation with the attending Physician and the patient:

  — reconstruction of the breast on which the mastectomy has been performed;

  — Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

  — Prostheses and physical complications at all stages of mastectomy, including lymphedemas.

Under WHCRA, mastectomy Benefits may be subject to annual Deductibles and Coinsurance consistent with those established for other Benefits under the Plan of coverage.

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

HUMAN ORGAN, TISSUE AND BONE MARROW TRANSPLANT SERVICES

All transplants are subject to Precertification 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.

Precertification 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 Precertification is obtained. Failure to obtain Precertification will result in denial of Benefits. The Plan has the sole and final authority for approving or declining requests for Precertification.

- **DEFINITIONS**

  In addition to the definitions listed under the ***DEFINITIONS*** section of this 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.

— **Precertification**

Certification from the Claims Administrator that, based upon the information submitted by the Covered Person's attending Physician, Benefits will be provided under the Plan. Precertification is subject to all conditions, exclusions and limitations of the Plan. Precertification 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**

— **Organ and Tissue Transplant Procedures**

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; and

- Kidney transplants.

— **Other Major Organ Transplant Procedures**

Subject to the Exclusions, conditions, and limitations of the Plan, Benefits will be provided for Covered Expenses rendered by a Hospital, Physician, or other Provider for the human organ and tissue transplant procedures set forth below.

- Heart Transplants

  Benefits will be provided for a heart transplant, provided the Covered Person:

  - has terminal heart disease with a life expectancy of 18 months or less;
  - has normal liver and kidney function;
  - has no concurrent malignancy, HIV (human immunodeficiency virus) infection or AIDS (acquired immunodeficiency syndrome); and
  - is psychologically stable and has a supportive social environment.

- Single Lung, Double Lung and Heart/Lung Transplants

  Benefits will be provided for a single lung, double lung or heart/lung transplant provided the Covered Person:

  - has end-stage cardiopulmonary or pulmonary disease with a life expectancy of 18 months or less;
  - has no concurrent malignancy, HIV infection or AIDS;
  - has normal liver and kidney function; and
  - is psychologically stable and has a supportive social environment.

- Liver Transplants

  Benefits will be provided for a liver transplant, provided the Covered Person:

  - has end-stage liver disease with a life expectancy of 18 months or less due to any of the following conditions:
    - extrahepatic biliary atresia;
    - primary biliary cirrhosis;
    - primary sclerosing cholangitis;
    - antigen-negative hepatitis B, antigen-negative or antigen-positive hepatitis C;
    - hepatic vein thrombosis (Budd-Chiari syndrome);
    - certain inborn errors of metabolism (such as Alpha-1-antitrypsin deficiency, Wilson's disease and primary hemochromatosis);
    - primary hepatocellular carcinoma; or

- primary autoimmune hepatitis;

- has normal kidney function;
- has no concurrent extrahepatic malignancy (including extrahepatic extension or primary hepatocellular carcinoma), HIV infection or AIDS; and
- is psychologically stable and has a supportive social environment.

No Benefits will be provided for a Covered Person with end-stage liver disease as a result of viral hepatitis where the Covered Person remains antigen positive (except for hepatitis C), or whose primary cause of liver damage is secondary to alcohol abuse, unless it can be demonstrated that the Covered Person has abstained from alcohol for a period of no less than 12 months.

- Intestinal Transplants

Benefits will be provided for a small bowel transplant using a cadaveric intestine for adult and pediatric Covered Persons with short-bowel syndrome who have established long-term dependency on total parenteral nutrition and who have developed severe complications due to parenteral nutrition, provided the Covered Person:

- has no concurrent malignancy, HIV infection or AIDS; and
- is psychologically stable and has a supportive social environment.

- Small Bowel/Liver or Multivisceral (Abdominal) Transplants

Benefits will be provided for a small bowel/liver transplant or multivisceral transplant for adult and pediatric Covered Persons with short bowel syndrome who have been managed with long-term parenteral nutrition and who have developed evidence of impending end-stage liver failure, provided the Covered Person:

- has no concurrent malignancy, HIV infection or AIDS; and
- is psychologically stable and has a supportive social environment.

- Pancreas Transplants

- Benefits will be provided for a combined pancreas/kidney transplant for diabetic Covered Persons with uremia, provided the Covered Person has no concurrent malignancy, HIV infection or AIDS; and is psychologically stable and has a supportive social environment.
- Benefits will be provided for a pancreas transplant after a prior kidney transplant for Covered Person with insulin dependent diabetes mellitus, provided the Covered Person has no concurrent malignancy, HIV infection or AIDS; and is psychologically stable and has a supportive social environment.
- Benefits will be provided for a pancreas transplant alone for Covered Persons with severely disabling and potentially life-threatening complications due to hypoglycemia unawareness and labile diabetes that persists in spite of optimal medical management, provided the Covered Person has no concurrent malignancy, HIV infection or AIDS; and is psychologically stable and has a supportive social environment.

- Islet Cell Transplants

  Benefits will be provided for an autologous islet cell transplant for a Covered Person undergoing total or near total pancreatectomy for intractable pain due to chronic pancreatitis.

— **Bone Marrow Transplants**

Not all autologous or allogeneic Bone Marrow Transplants or stem cell or progenitor cell support procedures, whether performed as independent procedures or in combination with other therapies, e.g., High-Dose Chemotherapy and/or High-Dose Radiation Therapy, are covered. Benefits for Bone Marrow Transplants are not available for treatment of all conditions, or at all stages of a condition, even if the Provider may recommend such treatment.

Subject to the Exclusions, conditions, and limitations of the Plan, Benefits will be provided for Covered Expenses rendered by a Hospital, Physician, or other Provider for Bone Marrow Transplants to treat a condition on the Claims Administrator's list of approved conditions and medical criteria for eligibility of Benefits (the "Approved List").

If coverage is requested for a Bone Marrow Transplant procedure to treat a condition other than those on the Claims Administrator's Approved List, the request will be individually reviewed. If it is determined by the Claims Administrator that the transplant is not Medically Necessary for the Covered Person, is Experimental or Investigational, or is otherwise excluded from coverage, Benefits will be denied.

Medical research regarding the effectiveness of Bone Marrow Transplant procedures is ongoing. The Claims Administrator periodically reviews conditions to determine eligibility for Benefits. The Covered Person or the treating Provider may obtain the Claims Administrator's Approved List of conditions and medical criteria for eligibility for Benefits upon request.

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

— 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 Expense.
- Autologous or allogeneic Bone Marrow Transplant and/or stem cell or progenitor cell treatment or rescue with or without High-Dose Chemotherapy or High-Dose Radiation Therapy for breast cancer patients with Stage I, II, or III disease or with refractory Stage IV disease.
- Tandem transplants for autologous or allogeneic bone marrow or stem cell or progenitor cell treatment or rescue, with or without High-Dose Chemotherapy and/or High-Dose Radiation Therapy.
- Small bowel transplants using a living donor.

- Liver transplant for a Covered Person with end-stage liver disease as a result of viral hepatitis where the Covered Person remains antigen positive (except for hepatitis C), or whose primary cause of liver damage is secondary to alcohol abuse, unless it can be demonstrated that the Covered Person has abstained from alcohol for a period of no less than 12 months.
- More than one organ of the same type, with the exception of a double-lung transplant done at one time. A heart-only, lung-only, or heart/lung transplant will be considered the same type organ.
- 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.
- 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 Expense in this Plan.
- Travel and lodging expenses are limited to $5,000 per transplant for patient and companion, subject to IRS guidelines.

— The transplant must meet the criteria established by the Claims Administrator for assessing and performing organ or tissue transplants, or Bone Marrow Transplant procedures.

— 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.

- **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 Expenses 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 Expenses 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 Plan as Experimental, Investigational or Unproven (see ***DEFINITIONS*** and ***EXCLUSIONS)*** are eligible for Benefits if the Bone Marrow Transplant meets all of the following criteria:

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

  — The Bone Marrow Transplant is available to the 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

An Ambulatory Surgical Facility is any public or private establishment with an organized medical staff of Physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing Outpatient Surgical Procedures, with continuous Physician services and registered professional nursing services whenever a patient is in the facility, and which does not provide services or other accommodations for patients to stay overnight.

PSYCHIATRIC CARE SERVICES

Mental and nervous related services as specified in the ***MEDICAL BENEFIT SUMMARY***. Covered Providers for mental and nervous related services are Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Licensed Professional Counselor, Psychiatrist, Psychologist (Ph.D.), or a Social Worker working under the direct supervision of a Physician (S.W., M.S.W., L.C.S.W., or A.C.S.W.).

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 or other Provider.

- Inpatient Medical Services

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

— Medical Care visits;

— Individual Psychotherapy;

— Group Psychotherapy;

— Psychological Testing;

— 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, 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.

Benefits for the treatment of any of the following Severe Mental Illnesses shall be equal to the Benefits provided under this Plan for treatment of all other physical diseases and disorders:

- schizophrenia;
- bipolar disorder (Manic-depressive Illness);
- major depressive disorder;
- panic disorder;
- obsessive-compulsive disorder; and
- Schizoaffective disorder.

DRUG AND ALCOHOL RELATED SERVICES

Drug and alcohol related services as specified in the ***MEDICAL BENEFIT SUMMARY***. Covered Providers for drug and alcohol related services are Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Licensed Professional Counselor, Psychiatrist, Psychologist (Ph.D.), or a Social Worker working under the direct supervision of a Physician (S.W., M.S.W., L.C.S.W., or A.C.S.W.).

AMBULANCE SERVICES

Charges for Medically Necessary local professional ground or air ambulance to the nearest facility equipped to handle the Illness or Injury.

- From your home to a Hospital;
- From the scene of an Accident or Medical Emergency to a Hospital;
- Between Hospitals;
- Between a Hospital and a Skilled Nursing Facility;
- From the Hospital to your home.

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

PRIVATE DUTY NURSING SERVICES

Private-duty nursing charges of a Registered Graduate Nurse (R.N.) in or out of a Hospital or a Licensed Practical Nurse (L.P.N.) in a Hospital. Private-Duty Nursing services are covered only to the extent the services enable a condition to improve, are Medically Necessary and are prescribed by a Physician.

SKILLED NURSING FACILITY SERVICES/EXTENDED CARE FACILITY

Charges for Skilled Nursing Facility/Extended Care Facility care will be considered a stay to which these provisions apply if all these conditions are met:

- The Covered Person had a Hospital stay;
- The Covered Person's Physician recommends the Skilled Nursing Facility/Extended Care Facility stay for recovery from an Illness or Injury that caused the Hospital stay or from a related Illness or Injury;
- The Skilled Nursing Facility/Extended Care Facility stay starts:
  - within 14 days after discharge from the Hospital stay; or
  - within 14 days after a related Skilled Nursing Facility/Extended Care Facility stay;
- The Covered Person is under the continuous care of the person's Physician; and
- The Covered Person's Physician certifies that the person needs 24 hour a day nursing care.

Related Skilled Nursing Facility/Extended Care Facility stays: Separate Skilled Nursing Facility/Extended Care Facility Stays of a Covered Person are considered related unless:

- Between the stays, the Covered Person is fully recovered from the Illness or Injury that caused the prior stay;
- The stays result from wholly unrelated causes; or

- In the case of an Employee's stay, the Employee meets the Actively at Work Requirement between the stays.

Skilled Nursing Facility Services are subject to the Precertification guidelines of this 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 this Plan.

CONVALESCENT CARE (INPATIENT REHAB)

Coverage is provided for Inpatient Hospital Services, Physical Therapy, Speech Therapy, and Occupational Therapy provided by a rehabilitation department of a Hospital, or other plan approved rehabilitation facility, after the acute care stage of Illness or Injury.

Rehabilitation Care is limited to 90 days of Inpatient Care per Plan Year.

Convalescent Care/Inpatient Rehab requires additional precertification for extended services. Failure to comply with these guidelines will result in a $500 reduction in Benefits for Convalescent Care/Inpatient Rehab if, upon receipt of a claim, Benefits are payable under this Plan.

HOME HEALTH CARE SERVICES

Charges for Home Health Care expenses made by a licensed, federally certified Home Health Care Agency for services and supplies that are ordered by a Physician in writing, and furnished to the patient in the home in accordance with a Home Health Care Plan, as specified in the ***MEDICAL BENEFIT SUMMARY***. The following services are covered under Home Health Care:

- Part-time or intermittent nursing care provided by a Registered Graduate Nurse (R.N.), or by a Licensed Practical Nurse (L.P.N.), a vocation nurse, or a public health nurse who is under the direct supervision of a Registered Graduate Nurse;

- Part-time or intermittent home health aide services that consist primarily of caring for the patient, and are under the supervision of an R.N. or L.P.N.;

- Medical supplies, drugs and medicines prescribed by a Physician, and laboratory services provided by or on behalf of a Hospital, but only to the extent that such charges would have been covered if the Covered Person had remained in the Hospital or an Extended Care Facility;

- Visits for Physical, Respiratory, Occupational or Speech Therapy; and

- Visits for nutrition counseling provided by or under the supervision of a registered dietitian.

Home Health Care requires that:
- A confinement will be necessary if Home Health Care is not provided; and

- The necessary care cannot be provided from someone living at the residence or from family members.

Each visit by a Registered Graduate Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) to provide nursing care, each visit by a therapist to provide Physical Therapy, and each visit of up to 4 hours by a home health aide will be considered as one Home Health Care visit.

- **Home Infusion Therapy** - Charges for Home Infusion Therapy, including the administration of nutrients, antibiotics, and other drugs and fluids intravenously, or through a feeding tube.

Benefits for Home Health Care are subject to a 120 visit Plan Year Maximum.

Home Health Care is subject to the Precertification guidelines of this 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 this Plan.

HOSPICE SERVICES

Charges by a licensed hospice facility, up to the maximum limits as shown in the ***MEDICAL BENEFIT SUMMARY***. Services are limited to terminally ill patients. Services must be approved by Blue Cross and Blue Shield of Oklahoma. Eligible Expenses will include the following charges:

- Nursing care by a Registered Graduate Nurse (R.N.), or by a Licensed Practical Nurse (L.P.N.), a Vocational Nurse or a public health nurse who is under the direct supervision of a Registered Graduate Nurse;
- Physical Therapy, Occupational, and Speech Therapy when rendered by a licensed therapist;
- Medical supplies, including drugs and biologicals, and the use of medical appliances;
- Physician services;
- Psychological and dietary counseling;
- Services, supplies, and treatment deemed Medically Necessary and ordered by a licensed Physician.

DENTAL SERVICES CONSIDERED UNDER THE MEDICAL PLAN

- Accidental Injury - Dental care under the Medical Plan is limited Accidental Injury to sound natural teeth that occurs while covered by this Plan. Injury resulting from chewing or biting will not be considered an Accidental Injury; and
- Dental Oral Surgery - The following oral surgeries and services will also be considered:
  - — the correction of congenital abnormalities of the jaw;
  - — reduction of fractures of facial bones;
  - — excisions of:
    - mandible joints;
    - teeth partly or completely impacted in the bone of the jaw;
    - teeth that will not erupt through the gum;
    - other teeth that cannot be removed without cutting into bone;

- the roots of a tooth without removing the entire tooth; and
- cysts, tumors, or other diseased tissues;

— incision of accessory sinus, mouth, salivary glands, or ducts;

— plastic reconstruction or repair of the mouth or lips to correct Accidental Injury;

— alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement;

— non-surgical treatment of infections or diseases. This does not include treatment related to the teeth;

— surgical removal of impacted teeth

— Facility and Anesthesia Coverage for Dental Services performed in a Hospital Setting

— dental work, Surgery, and orthodontic treatment needed to remove, repair, replace, restore, or reposition natural teeth damaged, lost, or removed, or other body tissues of the mouth fractured or cut due to Injury. Any such teeth must have been free from decay, in good repair, and firmly attached to the jawbone at the time of the Injury. If the dental work involves a crown, denture, bridgework, or any in-mouth appliance, Covered Medical Expenses will include only charges for the first denture or fixed bridgework to replace lost teeth, the first crown needed to repair each damaged tooth, and an in-mouth appliance used in the first course of orthodontic treatment after the Injury.

- Charges for dental work to sound natural teeth directly related to Surgery or extractions (including veneers) for a Medically Necessary service, i.e. cancer (treatment such as radionecrosis of teeth) are covered 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.

PODIATRY

Treatment for the following foot conditions: (a) weak, unstable or flat feet; (b) bone spurs; (c) injections into feet; (d) bunions, when an open cutting operation is performed; (e) non-routine treatment of corns or calluses; (f) toenails when at least part of the nail root is removed; (g) any Medically Necessary surgical procedure required for a foot condition; or (h) orthotics, including orthopedic shoes when an integral part of a leg brace or diabetics' shoes, limited to one orthotic device per year.

PROSTHETIC APPLIANCES

Devices, along with pertinent supplies, which replace all or part of an absent body organ and which are Medically Necessary for the alleviation or correction of conditions arising out of bodily Injury or Illness covered by this 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 Expense 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 due to changes in the size of the limb being augmented.

ORTHOTIC DEVICES

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

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 (except for Diagnosis of Diabetes);
- Elastic stockings (except for Diagnosis of Diabetes);
- Garter belts or similar devices;
- Orthopedic shoes.

SERVICES RELATED TO CLINICAL TRIALS

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

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

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

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

WIGS OR OTHER SCALP PROSTHESES

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

Medical Exclusions

Certain medical services are not covered under this Plan. No Claims will be considered for the following:

Abortion - Elective abortions, if not medically indicated to safeguard the life of the mother.

Alternative Therapy - Acupressure therapy, massage therapy, primal therapy, psychodrama, megavitamin therapy, bioenergetic therapy, carbon dioxide therapy, hypnotism, myo-functional therapy, rolfing, or biofeedback.

Blood - Blood or blood plasma that is donated or replaced, and/or blood donor expenses.

Complications - Services related to complications of a non-covered procedure.

Cosmetic Services - A treatment will be considered cosmetic for either of the following reasons:

- Its primary purpose is to beautify; or
- There is no documentation of a clinically significant impairment, meaning decrease in function or change in physiology due to Illness, Injury, or congenital abnormality.

Counseling - Charges for religious, career, financial, marital, or family counseling.

Court-Ordered - Charges for any court-ordered rehabilitative treatment, service, or supply.

Custodial Care - Charges that are considered Custodial Care. Please refer to "***CUSTODIAL CARE***" under ***DEFINITIONS***.

Date of Coverage - Charges Incurred prior to the Effective Date of coverage, or charges Incurred after the termination date of coverage.

Dental - Charges for dental work or treatment unless specified under ***COMPREHENSIVE HEALTH CARE SERVICES***. The following dental-related services are not covered:

- In-mouth appliances, crowns, bridgework, dentures, tooth restorations, or any related fitting or adjustment services not related to an Injury;
- Root canal therapy;
- Routine tooth removal;
- The repair of any covered service;
- Non-surgical periodontal treatment;
- Dental cleaning, in-mouth scaling, planning, or scraping; or
- Myofunctional therapy;
- Implants for teeth.

Drugs - Charges for performance, athletic performance, or lifestyle enhancement drugs or supplies.
Educational - Charges for educational or vocational services, including but not limited to schooling, books, and supplies, except as specified in the ***COMPREHENSIVE HEALTH CARE BENEFITS*** section.

Employment Related - Treatment for an Injury or Illness arising out of employment (or self-employment) for wage or profit.

Exercise - Exercise or wellness programs, except for Physician supervised Cardiac Rehabilitation, Occupational Therapy, or Physical Therapy.

Experimental and Research-Oriented Medical Procedures - For details, refer to the definition "**EXPERIMENTAL/INVESTIGATIONAL/UNPROVEN**" under ***DEFINITIONS***.

Food - Foods and nutritional supplements including, but not limited to, home meals, formulas, foods, diets, vitamins and minerals (whether they can be purchased over-the-counter or require a prescription), except when provided during Hospitalization, and except for prenatal vitamins or minerals requiring a prescription.

Functional Therapy - Charges made for functional therapy for teaming or vocational disabilities or for speech, hearing, and/or occupational therapy, unless specifically covered under another provision of this Plan.

Genetic - Genetic testing and/or genetic counseling.

Government Coverage - Charges for services or supplies provided by the Veterans Administration or in any Hospital or institution owned, operated, or maintained by the United States Government for a service-related Illness or Injury.

Government Health Plan - Charges for services and supplies, which are provided by any government health plan except for state-sponsored medical assistance programs. In the case of a state-sponsored plan, any benefits will be paid to the state. Any amount paid will be considered Benefits paid under the Plan and will constitute a full discharge of liability to the extent of payment.

Growth Hormones - Charges related to growth hormone therapy.

Hair Loss - Care and treatment for hair loss including wigs, hair transplants, or any drug that promises hair growth, whether or not prescribed by a Physician, except the initial purchase of a wig after Radiation Therapy or Chemotherapy.

Home Health - Home Health Care expenses will not be covered if they are:

- Services or supplies not specified in the Home Health Care Plan;
- Services by a member of the patient's family or household;
- Services for a period during which the patient is not under the continuing care of a Physician;
- The services of any social worker; or
- Transportation services.

Hospice Care - Charges that are not covered under Hospice Care include, but are not limited to:

- Bereavement counseling;
- Respite Care
- Funeral arrangement;

- Pastoral counseling;
- Financial or legal counseling which includes estate planning or the drafting of a will;
- Homemaker or caretaker services which are not solely related to care of the Participant, including sitter or companion services for either the Participant who is ill or other members of the family;
- Transportation; or
- Housecleaning and maintenance of the house.

Hospital Admissions - Hospital Admissions that are primarily for diagnostic evaluations, Physical Therapy, or Occupational Therapy.

Hospital Employees - Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

Illegal Acts - Charges for treatment of Illness or Injury caused or contributed to by having engaged in an illegal or criminal occupation or any illegal or criminal activity other than misdemeanor traffic violations; e.g., assault, felony, riot, war or act of war, insurrection or civil disorder, strike, or while imprisoned unless the source of Injury is due to a medical or mental health condition or an act of domestic violence.

Immunizations - Charges for immunizations except as specified as covered in the ***MEDICAL BENEFIT SUMMARY COMPREHENSIVE HEALTH CARE SERVICES*** section**.**

Implants for Teeth – Implants for teeth are not covered under this medical Benefit under any circumstances.

Impulse Control Disorders - Diagnosis and/or treatment of impulse control disorders such as pathological gambling, conditions related to hyperkinetic syndromes, learning disabilities, behavioral problems, mental retardation for Inpatient confinement for environmental change.

Infertility – Coverage if provided up to the diagnosis of infertility.

Inpatient treatment - 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 required hospitalization or general anesthesia for dental care.

Liposuction - Charges for liposuction and/or related procedures.

Medical Supplies - Medical supplies such as, but not limited to elastic stockings, bandages, trusses, lumbar braces, garter belts, and similar items that can be purchased without a prescription.

Military Service - Charges for the following services:

- Charges Incurred while on active duty or training in a military service, Armed Forces, National Guard, or Reserves of any state or country;
- Charges resulting from an insurrection, armed aggression, or war, declared or undeclared; or
- Charges provided by the Department of Veterans Affairs or by the Department of Defense for a military service related Injury or disability for which the Covered Person is eligible for benefits, even if necessary action to obtain such benefits is not taken.

Miscellaneous Services - Charges related to the following: PPO discount amounts, "cash discounts," over-the-counter (OTC) items, shipping costs, interest charges accrued on balances due, telephone consultations, computer consultations, internet consultations, failure to keep scheduled appointments, completion of any form, for medical information, and/or sales tax.

Motor Vehicles - Charges for the purchase or rental of motor vehicles such as cars or vans, or the cost of with converting a motor vehicle to accommodate a disability.

Nicotine Related - Charges for the diagnosis and/or treatment of nicotine dependence, except as listed under "**Smoking Cessation Benefits**," which is found under ***COMPREHENSIVE HEALTH CARE SERVICES***.

No Charge - Services for which there is no charge.

Non-Allowable Charge - Charges which are in excess of the Allowable Charge, as determined by the Claims Administrator.

Non-Emergency Hospital Admissions - Charges for a Hospital Admission on a weekend or holiday. Hospital Benefits will not be considered under this Plan for Friday, Saturday, Sunday or holiday admissions unless the confinement is:

- Medically Necessary as determined by the Plan;
- For a Medical Emergency;
- For maternity; or
- For a next-day Surgical Procedure.

Non-Medically Necessary - Charges for services that are not Medically Necessary as determined by the Claims Administrator.

Non-Medical Related Examinations - Charges for care, treatment, services, or supplies when performed for any of the following reasons:

- For purposes of obtaining, maintaining, or otherwise relating to career, sports, camp, school, travel, employment, insurance, marriage, or adoption;
- Relating to judicial or administrative proceedings or orders;
- Conducted for the purpose of medical research, except as otherwise provided; or
- To obtain a license of any type.

Not Responsible - Charges that a Covered Person would not be responsible for in the absence of this Plan.

Not Recommended - Charges for care, treatment, services, or supplies not recommended and approved by a Physician, or when not under the regular care of a Physician.

Not Specified - Charges for services, treatments, or supplies that are not specified as covered under this Plan.

Obesity - Charges for treatment of obesity, including morbid obesity, regardless of the patient's history or diagnosis, including but not limited to the following: weight reduction or dietary control programs; prescription or nonprescription drugs or medications such as vitamins (whether to be taken orally or by injection), minerals, appetite suppressants, or nutritional supplements; and any complications resulting from weight loss treatments or procedures.

Organ and Tissue Transplant - Services that are not covered relating to an organ and tissue transplant are:

- Services or supplies related to any transplant involving mechanical organs;
- Animal to human organ and tissue transplants; and
- Expenses associated with the purchase of any organ or tissue.

Orthotic Devices - Charges for orthotic devices such as arch supports or in-shoe supports, orthopedic shoes, elastic supports, or exams to prescribe or fit such devices, shoes, or supports, unless part of a brace.

Outside the US - Charges for medical expenses if the Covered Person leaves the United States, the U.S. Territories, or Canada for the express purpose of receiving medical treatment other than for an emergency.

Provider - Charges which are not performed by or upon the direction of a Physician or other Provider.

Personal Convenience - Personal convenience or comfort items such as air conditioners, air purifiers, water purifiers, dehumidifiers, orthopedic mattresses, hypoallergenic pillows, blood pressure devices, scales, exercise cycles, elastic bandages, non-prescription drugs and medicines, first-aid bandages, waterbeds, and non-hospital adjustable beds.

Relationships - Professional services performed by a person who ordinarily resides in the Participant's home or is related to the Participant as a Spouse, parent, child, brother, sister, brother-in-law, or sister-in-law, whether the relationship is by blood or exists in law.

Replacement Braces - Replacement of braces of the leg, arm, back, neck or artificial arms or legs, unless there is sufficient change in the Participant's physical condition to make the original device no longer functional, or the age of the brace makes it no longer functional.

Sexual Dysfunction - Charges related to the diagnosis and/or treatment of sexual dysfunction, including sex transformation, transgender Surgery, Surgery, or impotence (unless resulting from a physical Illness or Injury).

Specialty Drug - Specialty medications include high-cost injectables and infused, oral or inhaled drugs used to treat chronic diseases.

Speech Therapy - Speech Therapy for remedial purposes, educational purposes, or for initial development of natural speech. This would apply to children who have not established a natural speech pattern for reasons that do not relate to a congenital defect. In these cases, Speech Therapy would be considered educational in nature and not eligible for coverage. Speech Therapy would not meet coverage criteria for the following conditions: chronic voice strain, congenital deafness, delayed speech, developmental or learning disorders, environmental or cultural speech habits, hoarseness, infantile articulation, lisping, mental disability, resonance, stuttering, and voice defects of pitch, loudness, and quality.

Surrogate Parent - Charges for medical services rendered to a surrogate parent for purposes of childbirth, or charges for medical services rendered to a Covered Person acting as a surrogate parent.

Temporomandibular Joint Dysfunction - Charges for treatment of temporomandibular joint dysfunction, including but not limited to diagnostic procedures splints, orthodontic/orthopedic appliances, restoration necessary to increase vertical dimension or to restore or maintain functional or centric occlusion, alteration of teeth or jaws, Physical Therapy, and medication and behavioral modification related to conditions of temporomandibular joint syndrome or any other conditions involving the jaw joint, adjacent muscles or nerves, regardless of cause or diagnosis.

Vision Services – Except as specifically covered in ***COMPREHENSIVE HEALTH CARE SERVICES***, charges for:

- Eyeglasses or lenses of any type;
- Eye Surgery such as, but not limited to, radial keratotomy, LASIK, and P.R.K., when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring); or
- Orthoptics or visual training.

This exclusion does not apply to aphakic patients or soft lenses and sclera shells intended for use as corneal bandages.

Vitamins/Supplements - Charges for vitamins not requiring a prescription, herbal medicines, appetite suppressants, nutritional supplements, and/or tobacco dependency drugs.

Weight Loss - Charges for the diagnosis and/or treatment relating to weight loss or dietary control, including the diagnosis and/or treatment of obesity, whether or not it is part of the treatment plan for another Illness.

Workers' Compensation - Charges that are compensated under Workers' Compensation laws, including any services or supplies applied toward any deductible under the employer's Workers' Compensation coverage. This exclusion includes any services or supplies that could have been compensated under Workers' Compensation laws if all applicable requirements had been met, including, but not limited to, notice of Injury, timely filing of Claims, and medical treatment authorization.

PRESCRIPTION DRUG BENEFITS/RXBENEFITS / OPTUM

Prescription Drugs can be purchased from any RxBenefits / Optum Pharmacy. The Prescription Drug Copayment and/or Coinsurance amounts must be paid at the time of purchase. The Covered Person must present their medical Identification Card to the pharmacist when presenting the Prescription Order. The Pharmacy will forward the Prescription Claim directly to RxBenefits / Optum who will reimburse the Pharmacy for the Prescription Drug charge in excess of the drug Copayment and/or Coinsurance amount.

For the location of the RxBenefits / Optum, telephone RxBenefits / Optum at 1-800-880-1188 or go online to.

Please contact RxBenefits / Optum 1-800-880-1188 for any questions concerning the Prescription Drug Plan.

PRESCRIPTION DRUG DEFINITIONS

A GENERIC PRESCRIPTION DRUG is a pharmaceutical product manufactured and sold under the chemical common or official name. The generic equivalent of a Brand Name Drug must meet the same standards for safety, purity, strength, and effectiveness as the Brand Name Drug. The Generic and the Brand Name Drug have the identical chemical composition and therapeutic effect.

A BRAND NAME PRESCRIPTION DRUG is a pharmaceutical product manufactured and sold under the name assigned by the developer/manufacturer.

A FORMULARY DRUG is a Brand Name Drug that is selected by the Prescription Drug Program based on the drug's ability to meet a patient's needs at a lower cost.

PRESCRIPTION DRUG EXCLUSIONS

The following are not covered under the Prescription Drug portion of this Plan;

- More than a 90-day supply for a pharmacy prescription;
- Administration or injection of any drug;
- Any refill of a prescription more than one year after the latest prescription;
- Any drug provided while Inpatient;
- Immunization agents;
- Biological sera and blood products;
- Nutritional supplements;
- Smoking cessation aids or drugs, except as listed under Tobacco Prescription Drug Therapy which is found under ***COMPREHENSIVE HEALTH CARE SERVICES***; or
- Appetite suppressants.

This section tells:

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

BENEFITS TO WHICH YOU ARE ENTITLED

We provide only the Benefits specified in this Summary.

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

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

PRIOR APPROVAL

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

Your Properly Filed Claim must be furnished to the Plan within one year from the date the Covered Service is rendered.

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

LIMITATION OF ACTIONS

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

PAYMENT OF BENEFITS

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

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

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

Benefits under this Summary will be based upon the Allowable Charge (as we determine) for Covered Services. A Blue Preferred 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 Blue Preferred 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 Blue Cross and Blue Shield 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 us.

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 we may obtain a Provider discount for you on Covered Services you receive outside the state of Oklahoma.

DETERMINATION OF BENEFITS AND UTILIZATION REVIEW

The Plan, as 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 Plan will determine whether a service or supply is Medically Necessary under the Plan or if such service or supply is Experimental or Investigational. Blue Cross and Blue Shield of Oklahoma 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 Plan upon request and may be found on the Plan's Web site at www.bcbsok.com.

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

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

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

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

Failure of the Covered Person to comply with the Plan'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.

We do not furnish Covered Services but only pay for Covered Services you receive from Providers. We

are not liable for any act or omission of any Provider. We have no responsibility for a Provider's failure or refusal to give Covered Services to you.

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

AGENCY RELATIONSHIPS

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

COORDINATION OF BENEFITS

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

- **Definitions**

  In addition to the definitions of this Summary, 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 Plan Year, then the Benefits we provide for that Plan Year will be determined according to this provision.

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

When we are 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 Plan, and as a Dependent under another, then the employee coverage pays first.

— When a Dependent child is covered under two Plans, the Plan covering the child as a Dependent of the parent whose birthday falls earliest in the Calendar Year pays first. (If one Plan does not follow the "birthday rule" provision, then the rule followed by that Plan 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 Plan 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 Plan shall:

- Assume the Other Contract is required to determine its benefits first;
- Assume the benefits of the Other Contract are identical to the Benefits of this coverage and pay its Benefits accordingly.

Once the Plan 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 coverage will be adjusted accordingly (if the above rules require it).

— If the other carrier reduces your benefits because of payment you received under this coverage and the above rules do not allow such reduction, then the Plan will advance the remainder of its full Benefits under this coverage as if 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 we have the right to pay whoever paid under the Other Contract the amount we determine is necessary under this provision. Amounts so paid are Benefits under the Plan and we are discharged from liability to the extent of such amounts paid for Covered Services.

- **Right Of Recovery**

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

PLAN RIGHTS TO THIRD-PARTY PAYMENTS

If the Plan pays any Benefits or otherwise incurs any expenses or losses for you or your Dependent because of an accident, Injury, Illness, sickness, or other condition which may have been caused by a third party (the "covered condition"), the Plan has certain rights to third-party payments related to that covered condition. The Plan's rights to third-party payments are described below. If you have any questions about Plan's rights to third-party payments, contact the Plan Administrator.

The Plan's rights to third-party payments include a right of subrogation. This right allows the Plan to be subrogated to any and all claims, demands, actions and rights of recovery of you or your Dependent against a third-party, as well as the heirs, guardians, executors, or other representatives of you or your Dependent who may initiate or have recovery rights against a third-party, on account of a covered condition. This means that the Plan has rights against any third-party who may have been responsible for the covered condition (including, but not limited to, any person, party, entity, insurance company, corporation, or firm). For example, if another person injures you or your Dependent in an auto accident, the Plan can sue that person (or any other party responsible or liable for that person, such as that person's insurer) to recover on account of the Benefits the Plan has paid in relation to such Injury.

In addition to the Plan's right of subrogation, the Plan has a property right to and equitable interest in any and all third-party payments made to or on behalf of you or your Dependent on account of a covered condition. This right to and interest in third-party payments exists without regard to whether the Plan exercises its right of subrogation. The Plan's equitable interest in such third-party payments means that third-party payments made to or on behalf of you or your Dependent on account of a covered condition belong to the Plan, to the extent of Benefits paid or expected to be paid in relation to such covered condition.

The Plan also has a right to offset Benefits otherwise payable under the Plan against any amount belonging to the Plan as a result of the Plan's rights to third-party payments. The Plan's right of offset means that if you your Dependent, or your or your Dependent's representative does not return any amounts belonging to the Plan as a result of the Plan's rights to third-party payments, the Plan may recover part or all of the amount owed by offsetting that amount against Benefits otherwise payable. The Plan's right of offset exists with respect to Benefits it has not paid (for previously incurred expenses) and to any future Benefits otherwise payable under the Plan.

Here are some additional things you should know about the Plan's rights to third-party payments:

- The Plan's rights apply to any and all third-party payments for any expenses or losses related to the covered condition (including, but not limited to, payments or recoveries under no-fault coverage, malpractice, personal injury, pain and suffering, wrongful death, medical reimbursement, financial responsibility, uninsured or underinsured insurance coverage, and medical coverage of any type regardless of the purchaser).

- The Plan's rights come first from any recovery, regardless of source or fault, even if you or your Dependent is not made whole for damages from the covered condition (provided that the Plan's rights will be subject to deduction of any reasonable attorney's fees the Plan agrees in advance to pay).

- The Plan's rights include an equitable lien upon any interest you may have in any third-party payment received by you or your Dependent or that is obtained on your or your Dependent's behalf on account of the covered condition. This means that the Plan automatically has a lien upon any third-party payment received by you or your Dependent. Subject to this equitable lien, the Plan generally pays Benefits for the eligible expenses of a covered condition if you:

  - Provide information on the incident and sign and return an acknowledgement of the Plan's rights to third-party payments to the Plan Administrator or Claims Administrator, and

  - Sign and deliver any needed documents to the Plan Administrator or Claims Administrator, and

  - Do whatever is necessary to secure the Plan's rights to third-party payments and ensure the return of any third-party payments belonging to the Plan, and

  - Do nothing to prejudice or jeopardize the Plan's rights to third-party payments.

    If you or your Dependent fails to satisfy the above conditions, the Plan reserves the right to pay no Benefits with respect to costs incurred in connection with the covered condition.

- You, your Dependent Child, or your, or your Dependent's representative (including your or your Dependent's attorney) must hold in constructive trust for the Plan any third-party payment received in relation to a covered condition and belonging to the Plan pursuant to the terms of this provision. You must return to the Plan from that third-party payment the amount of any and all Benefits that the Plan has paid in relation to the covered condition, as soon as the third-party payment is made, regardless of the source and regardless of fault. This includes payments and recoveries granted by whole, partial, or undifferentiated judgments.

- The Plan's rights to third-party payments exists with respect to Benefits it has already paid, Benefits which it has not paid but for which expenses have been incurred and estimated future Benefits. The Plan will not be responsible in any way for any fees or costs associated with any payment or recovery

you pursue unless the Plan agrees to do so in writing. The amount you must return to the Plan under this provision will not exceed the amount of the proceeds from the third-party payment (after the deduction of any reasonable attorney's fees the Plan agrees in advance to pay). However, this payment must be made to the Plan regardless of whether you, your Dependent Child, or your or your Dependent's representative is fully compensated for the covered condition.

- If the Plan takes legal action against you, your Dependent, or your or your Dependent's representative to enforce the Plan's rights to third-party payments, then you, your Dependent Child, or your or your Dependent's representative will be responsible for paying all costs of collection, including reasonable attorneys' fees of the Plan.

- The Plan's rights to third-party payments does not limit your or your Dependent's rights to proceed against any party for any expenses or other losses incurred due to the fault of a third party.

- If any amount belonging to the Plan as a result of its rights to third-payments is returned to the Plan, the Lifetime maximum benefit levels for you or your Dependent will be restored by a corresponding amount.

RIGHTS OF RECOVERY

In the event of any overpayment of benefits by this Plan, the Plan will have the right to recover the overpayment. If a Covered Person is paid a benefit greater than allowed in accordance with the provisions of this Plan, the Covered Person will be required to refund the overpayment. If payment is made on behalf of a Covered Person to a Hospital, Physician or other provider of health care, and the payment is found to be an overpayment, the Plan will request a refund of the overpayment from the provider. If the refund is not received from the provider, or from the Covered Person, the amount of the overpayment will be deducted from future benefits, if available. If future benefits are not available, the Covered Person will be required to refund the overpayment.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purposes of implementing the terms of this Plan, the Plan Administrator and the Claims Administrator retains the right to request any medical information from any insurance company or provider of service it deems necessary to properly process a claim. In accordance with applicable law, the Plan Administrator and the Claims Administrator may, without consent of the Covered Person, release or obtain any information it deems necessary. Any person claiming benefits under this Plan shall furnish to the Plan Administrator and/or the Claims Administrator such information as may be necessary to implement this provision.

LIMITATIONS ON PLAN'S RIGHT OF RECOUPMENT/RECOVERY

The Plan will not seek recovery of any excess or erroneous payment made under this Summary 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.

PLAN/ASSOCIATION RELATIONSHIP

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

This program begins to pay only after the Deductible amount you incur toward eligible expenses shows on our records. When your Physician, Hospital, or other Provider of health care services submits bills for you, your Deductible will be recorded automatically and then your program will begin its share of the payment. If you file your own claims, you must submit copies of all your bills, even those you must pay to meet your Deductible. Then our records will show that you have Incurred the 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 Plan 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 Plan'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 shown in your directory.

PRESCRIPTION DRUG CLAIMS

To be eligible for discounts on Prescription Drugs and automatic claims filing, always use Participating Pharmacies. Keep in mind that you receive the highest Benefits under this program whenever your prescriptions are filled by a Participating 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 your Prescription Drug program. Be sure to include the diagnosis and the payment receipt with your completed claim form. If the Prescription Drug is covered under this program, any payment due will be sent directly to you, after we subtract any shared payment amounts which apply to your coverage.

HOSPITAL CLAIMS

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

AMBULATORY SURGICAL FACILITY CLAIMS

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

PHYSICIAN AND OTHER PROVIDER CLAIMS

If you are treated by a Physician or other Provider who does not have an agreement with us, you ordinarily have to pay the bill and then file the claim yourself, along with an itemized statement from your Physician

or other Provider. You will then be paid directly for Covered Services after we subtract your Deductible and/or Coinsurance amounts which apply to your coverage.

MEMBER−FILED CLAIMS

When you must file a claim yourself, you may obtain claim forms by contacting the nearest Plan 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 we 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, we must receive your claims for Covered Services within one year from the date the Covered Service is rendered.

BENEFIT DETERMINATIONS FOR PROPERLY FILED CLAIMS

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

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

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

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

DIRECT CLAIMS LINE

We have a direct line for claims and membership inquiries. You may call 1−800−94−BLUES (1−800−942−5837) between 8:00 a.m. and 6:00 p.m., Monday through Friday, whenever you have a question concerning a claim or your membership.

Claims Appeal Procedure

Blue Cross and Blue Shield of Oklahoma has established the following process to review your dissatisfactions, complaints and/or appeals. If you have designated an authorized representative, that person may act on your behalf in the appeal process.[2]

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. It is suggested 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 the appeal procedures described 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 the determination;
- A reference to the Plan provisions on which the determination is based, or the contractual or administrative basis or protocol for the determination;
- A description of additional information which may be necessary to perfect the claim and an explanation of why such material is necessary;
- Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care Provider, claim amount (if applicable) and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
- An explanation of the 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 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;

[2] The Plan has established procedures for you to designate an individual to act on your behalf with respect to a Benefit claim or an appeal of an Adverse Benefit Determination. A Provider or other health care professional with knowledge of your medical condition is permitted to act as your authorized representative or to bring an appeal on your behalf.

- Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
- An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant's medical circumstances, if the denial was based on Medical Necessity, Experimental, Investigational and/or Unproven treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;
- In the case of a denial of an Urgent Care Claim, a description of the expedited review procedure applicable to such claims. An Urgent Care Claim decision may be provided orally, so long as a written notice is furnished to the claimant within three days of oral notification; and
- Contact information for applicable office of health insurance consumer assistance or ombudsman.

TIMING OF REQUIRED NOTICES AND EXTENSIONS

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

- **"Urgent Care Claim"** is any pre-service request for Benefits that requires "*Precertification*", 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 Plan condition receipt of the Benefit on approval of the Benefit in advance of obtaining Medical Care.
- **"Post-Service Claim" (also known as "claim")** is any request for a Benefit that is not a "pre-service" claim, and whereby notification that a service has been rendered or furnished to you is submitted to the 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 Urgent Care 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 submit an Urgent Care Claim.

PRE-SERVICE CLAIMS

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

*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 Claims Administrator 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, 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 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 Plan both (1) determines that such an extension is necessary due to matters beyond the control of the Claims Administrator 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.

APPEAL PROCEDURES – DEFINITIONS

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

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

APPEAL PROCESS (LEVEL I)

- ***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 Determination***

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

An appeal of an Adverse Benefit Determination may be filed by you or a person authorized to act on your 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 the claim reviewed. The Claims Administrator will review its decision in accordance with the following procedure:

— Within 180 days after you receive notice of an Adverse Benefit Determination, you may write to your Claims Administrator's Administrative Office. The Claims Administrator will need to know the reasons why you do not agree with the Adverse Benefit Determination. Send your request to:

Appeal Coordinator - Customer Service Department
Blue Cross and Blue Shield of Oklahoma
P. O. Box 3283
Tulsa, 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 at the address listed above, or call the number shown 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 (or 30 days if the determination involves a Medical Necessity/appropriateness or Experimental, Investigational and/or Unproven decision) after the appeal has been received by the 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 to you or your authorized representative will include:

  — A reason for the determination;

  — A reference to the Plan provisions on which the determination is based, and the contractual or administrative basis or protocol for the determination;

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

  — An explanation of the 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 that decision; and

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

VOLUNTARY RE−REVIEW PROCESS (LEVEL II)

If you are not satisfied with the decision concerning the appeal, you may elect to submit an Adverse Benefit Determination to the Plan for re-review. The Plan will provide you with information about the Plan's voluntary re-review process.

To request a re-review of the Benefit determination, you should submit the request in writing to the following address:

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

The written request should include the name of the Covered Person, the Covered Person identification

number, the nature of the complaint, the facts upon which the complaint is based, ***and the resolution you are seeking***. Necessary facts are: dates and places of services, names of Providers of services, place of hospitalization and types of services or procedures received (if applicable). You should include any documentation, including medical records, that you want to become a part of the review file. The Plan may request further information if necessary.

A Precertification Request Involving Urgent Care may be re-reviewed by calling the Precertification number shown on the Identification Card.

EXTERNAL REVIEW (LEVEL III)

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; and
  - — You or your authorized representative have provided all the information and forms required to process an external review.

You will be notified within 1 business day after the Claims Administrator completes the preliminary review if your request is eligible or if further information or documents are needed. You will have the remainder of the 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, the Claims Administrator 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 a

similar nationally-recognized accrediting organization. Moreover, the Claims Administrator will take action against bias and to ensure independence.

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.

You are not obligated by the Plan to pursue the Plan's voluntary re-review process or an external review in any specific order. You are not required to exhaust the voluntary re-review process before bringing a civil action. If the review process does not provide a satisfactory resolution to the claim for Benefits, legal remedies are available, including pursuing the claim in court.

Your ERISA Rights

As a participant in this Plan, you may be entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

ERISA RIGHTS

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, 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 copies of documents governing the operation of the plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared, in which case 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, your spouse or your 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.

You should be provided with 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.

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 the 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 or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a plan benefit or exercising your rights under ERISA.

ENFORCE YOUR RIGHTS

If your claim for a 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 materials 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 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 Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, and if you have exhausted the claims procedures available to you under the plan, you may file suit in a state or 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 to be 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.

Definitions

This section defines terms that have special meanings in this Summary. 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. For purpose of this paragraph, an Employee will be considered Actively at Work if the Employee's absence from work is due to health reasons.

ALLOWABLE CHARGE

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

- **Blue Preferred 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 Blue Preferred PPO Provider Agreement.

- **Out-of-Network Provider** — the Provider's usual charge, up to the amount that the Plan would reimburse a Blue Preferred PPO Provider for the same service.

NOTE: For covered health care services received outside the state of Oklahoma, if the claim for those services is filed with the Blue Cross and Blue Shield Plan (Host Plan) servicing the area, the "Allowable Charge" will be determined by the on-site Blue Cross and Blue Shield Plan. Payment will be based upon the Provider payment arrangements in effect between the Provider and the on-site Plan. In instances where the claim is not filed with the Host Plan the Allowable Charge for your out-of-network claims will be based upon the amount the Plan would have reimbursed a Blue Preferred PPO Provider for the same service.

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.

ANNUAL ENROLLMENT PERIOD

A period of days preceding each Plan Year during which an individual who previously declined coverage may Enroll for coverage under the Plan.

BENEFITS

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

BLUECARD PPO PROVIDER

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

BLUE PREFERRED PPO PROVIDER

A Provider who has entered into an agreement with the Plan to bill the Plan directly for Covered Services, and to accept the Plan's Allowable Charge as payment in full for such Covered Services.

CLAIMS ADMINISTRATOR

BlueCross BlueShield of Oklahoma

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.

COVERED PERSON

The Member and each of his or her Dependents (if any) covered under this Summary.

COVERED SERVICE

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

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.

DEPENDENT

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

DIAGNOSTIC SERVICE

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

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

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 Plan's criteria of Medical Necessity for the given diagnosis.

EFFECTIVE DATE

The date when your coverage begins.

ELIGIBLE PERSON

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

EMERGENCY CARE

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

- serious jeopardy to the 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

Flintco, LLC

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/UNPROVEN

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

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

FAMILY COVERAGE

Coverage under this Summary for the Member and one or more of the Member's Dependents.

GROUP HEALTH 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 MAINTENANCE ORGANIZATION (HMO)

An organized system of health care providing a comprehensive package of health services, through a group of Physicians, to a voluntarily enrolled membership, within a particular geographic area, on a fixed prepayment basis.

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 Member by the Plan, bearing the Member's name, identification number, and Group number.

INCURRED

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

INITIAL ENROLLMENT PERIOD

The 30-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.

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 judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

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

MEDICARE

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

MEMBER

An Eligible Person who has enrolled for coverage.

MEMBER ONLY COVERAGE (OR SINGLE COVERAGE)

Coverage under this Summary for the Member only.

MEMBER, SPOUSE AND CHILDREN COVERAGE (OR FAMILY COVERAGE)

Coverage under this Summary for the Member, his or her spouse and Dependent child(ren).

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.

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 PROVIDER

A Provider that has not entered into an agreement with the Plan to be a part of its Blue Preferred PPO or BlueCard PPO Provider networks.

OUTPATIENT

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

PARTICIPATING EMPLOYER

An employer related to Flintco, LLC which offers participation in this Plan to its eligible Employees.

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

Flintco, LLC Group Health Plan as amended from time to time. The Plan is the medical benefits portion of the Flintco, LLC Welfare Benefit Plan.

PLAN ADMINISTRATOR

Flintco, LLC Welfare Benefits Committee

PLAN YEAR

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

PRECERTIFICATION

Certification from the Plan before the services are rendered that, based upon the information presented by the Covered Person or his/her Provider at the time Precertification is requested, the proposed treatment meets the Plan's guidelines for Medical Necessity.

Precertification 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.

PROPERLY FILED CLAIM

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

PROVIDER

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

QUALIFYING EVENT

Any one of the following events which, but for the COBRA Continuation Coverage provisions of this Summary, 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.

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 coverage, except that neither a Waiting Period nor an affiliation period is taken into account in determining a Significant Break In Coverage.

SKILLED NURSING FACILITY

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

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

SPECIAL ENROLLMENT PERIOD

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

SURGERY

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

THERAPY SERVICE

The following services and supplies ordered by a Physician 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.

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

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 during a Special Enrollment Period, any period before such late or special enrollment is not a Waiting Period.

Other Plan Identifying Information for Purposes of ERISA

NME OF PLAN: Flintco, LLC Group Health Plan, a component benefit under the Flintco, LLC Welfare Benefit Plan

PLAN NUMBER: 502

TYPE OF PLAN: Welfare Benefit Plan

EMPLOYER IDENTIFICATION NUMBER: 27-3321079

NAME, ADDRESS AND TELEPHONE NUMBER OF EMPLOYER
Flintco, LLC
1624 W. 21st St.
Tulsa, OK 74107
(918) 710-2164

EMPLOYER TAX IDENTIFICATION NUMBER: 27-3321079

NAME, ADDRESS AND TELEPHONE NUMBER OF PLAN ADMINISTRATOR
Flintco, LLC Welfare Benefits Committee
1624 W. 21st St.
Tulsa, OK 74107
(918) 710-2164

AGENT FOR SERVICE OF LEGAL PROCESS
Flintco, LLC Welfare Benefit Plan
1624 W. 21st Street
Tulsa, OK 74107

PLAN YEAR: June 1 – May 31

FUNDING
This Plan is self-funded by the Employer. Contributions are determined by the Plan Sponsor and include Employer contributions and contributions by participants.

TYPE OF ADMINISTRATION
The Plan is administered by the Plan Administrator, who supervises the operation of the Plan and who interprets the Plan's provisions in accordance with the terms of the Plan. The Claims Administrator pays for benefits on behalf of the Employer and administers claims.