Dear Member:

Blue Cross and Blue Shield of Oklahoma (BCBSOK) is announcing important changes to your health care plan. The enclosed information describes the changes in detail. Please review and keep this with your Certificate of Benefits (benefits booklet) and other benefit information.

If you have any questions, please call the customer service number listed on the back of your Blue Cross and Blue Shield of Oklahoma ID card.

Sincerely,

Linza Jones
Vice President, Marketing and Sales

Enclosure(s)

Notice: To obtain a copy of BCBSOK’s Notice of Privacy Practice (NOPP), please visit our website: www.bcbsok.com/legalDisclaimer.html or email NOPP@BCBSOK.com or call the number on the back of your ID card.
AMENDMENTS RESPECTING WOMEN’S PREVENTIVE CARE SERVICES

IT IS AGREED that the Certificate of Benefits to which this amendment is issued for attachment is amended by the addition of the following provisions:

A. AMENDMENT RESPECTING PREVENTIVE CARE SERVICES

Preventive Care Services with respect to women are amended to include the following Covered Services when performed by BlueChoice or BlueCard Providers and will not be subject to Deductible, Copayment, Coinsurance or dollar maximums:

1. Breastfeeding Support, Services and Supplies – Benefits will be provided for breastfeeding counseling and support services rendered by a Provider for pregnant and postpartum women. Benefits include the rental (or, at the Plan’s option, the purchase if it will be less expensive) of manual breast pumps, accessories and supplies.

2. Contraceptive Services – Benefits will be provided for the following contraceptive services when prescribed by a licensed Provider for women with reproductive capacity:
   - contraceptive counseling;
   - FDA-approved prescription devices and medications;
   - over-the-counter contraceptives; and
   - sterilization procedures (tubal ligation), but not including hysterectomy.

Coverage includes contraceptives in the following categories:
   - progestin-only contraceptives;
   - combination contraceptives;
   - emergency contraceptives;
   - extended-cycle/continuous oral contraceptives;
   - cervical caps;
   - diaphragms;
   - implantable contraceptives;
   - intra-uterine devices;
   - injectables;
   - transdermal contraceptives; and
   - vaginal contraceptive devices.

NOTE: Prescription contraceptive medications are covered under the Outpatient Prescription Drug Benefits section of your Certificate, if applicable.
The contraceptive drugs and devices listed above may change as FDA guidelines are modified. Coinsurance or Copayment amounts will not apply to FDA-approved contraceptive drugs and devices on the Contraceptive Information list. You may access the Web site at www.bcbsok.com or contact customer service at the toll-free number on your Identification Card.

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

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

B. AMENDMENT RESPECTING EXCLUSIONS

The exclusion of contraceptive medications or devices shown in the Exclusions section is hereby removed and replaced with the following:

- For female contraceptive devices when not prescribed by a licensed Provider, including over-the-counter contraceptive products. Contraceptive medications or devices for male use are excluded.

C. AMENDMENT RESPECTING CONTRACEPTIVE COVERAGE

If your Group has indicated to the Plan that it qualifies for a one-year temporary exemption or a permanent exemption with respect to the federal requirement to cover contraceptive services without cost sharing, coverage under your Group Health Plan will not include coverage for contraceptive services. Questions regarding this exemption should be directed to your Group Administrator.

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

Except as changed by this amendment, all terms, conditions, limitations and exclusions of the Contract or Certificate to which this amendment is attached will remain in full force and effect.

For Contracts in effect on or after August 1, 2012, this amendment is effective on the Group Contract Date or Contract Date Anniversary.

[Signature]

President of Blue Cross and Blue Shield of Oklahoma
BlueCross BlueShield of Oklahoma
1400 South Boston • P. O. Box 3283 • Tulsa, OK 74102-3283

AMENDMENT RESPECTING COMPLAINT/APPEAL PROCEDURE

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

A. The “Preauthorization” or “Preauthorization/Precertification” provisions are amended so that the paragraph entitled “Precertification Requests Involving Urgent Care” is hereby deleted and replaced by the following:

- Preauthorization Requests Involving Urgent Care

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

- could seriously jeopardize the life or health of the Subscriber or the ability of the Subscriber to regain maximum function; or

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

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

B. The “Concurrent Review” or “Concurrent Review and Case Management” provisions are deleted in their entirety and replaced by the following:

CONCURRENT REVIEW

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

C. AMENDMENT RESPECTING COMPLAINT/APPEAL PROCEDURE

The “Complaint/Appeal Procedures” currently reflected in Certificate of Benefits, or in any amendment attached thereto, are hereby deleted and restated as follows:

COMPLAINT/APPEAL PROCEDURE

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

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

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

CLAIM DETERMINATIONS

When the Plan receives a Properly Filed Claim, it has authority and discretion under this Certificate to interpret and determine Benefits in accordance with the Certificate provisions. We will receive and review claims for Benefits and will accurately process claims consistent with administrative practices and procedures established in writing.

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

IF A CLAIM IS DENIED OR NOT PAID IN FULL

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

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

- The reasons for the determination;
- A reference to the Benefit provisions on which the determination is based, or the contractual, administrative or protocol for the determination;
• A description of additional information which may be necessary to perfect an appeal 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 our internal review/appeals and external review processes (and how to initiate a review/appeal or external review);

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

• In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by us;

• The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for Benefits;

• Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;

• An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant’s medical circumstances, if the denial was based on medical necessity, experimental treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;

• In the case of a denial of an Urgent Care Clinical Claim, a description of the expedited review procedure applicable to such claims. An urgent care claim decision may be provided orally, so long as a written notice is furnished to the claimant within 3 days of oral notification; and

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

TIMING OF REQUIRED NOTICES AND EXTENSIONS

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

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

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

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

**URGENT CARE CLAIMS**

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

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

**PRE-SERVICE CLAIMS**

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

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

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

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

CLAIM APPEAL PROCEDURES

- **Claim Appeal Procedures - Definitions**
  An “Adverse Benefit Determination” means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Benefit, including any such denial, reduction, termination, or failure to provide or make payment for, a Benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which Benefits are otherwise provided because it is determined to be Experimental, Investigational or unproven or not Medically Necessary or appropriate. If an ongoing course of treatment had been approved by us and reduces or terminates such treatment (other than by amendment or termination of this Certificate) before the end of the approved treatment period, that is also an Adverse Benefit Determination. A rescission of coverage is also an Adverse Benefit Determination. A rescission does not include a termination of coverage for reasons related to non-payment of premium.

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

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

  Upon receipt of an expedited pre-service or concurrent clinical appeal, we will notify the party filing the appeal, as soon as possible, but no more than 24 hours after submission of the appeal, of all the
information needed to review the appeal. Additional information must be submitted within 24 hours of request. The Plan shall render a determination on the appeal as soon as possible (taking into account medical exigencies) but no later than 72 hours after it receives the initial request, or within 48 hours after it receives the missing information (if the initial request is incomplete).

• How to Appeal an Adverse Benefit Determination

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

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

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

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

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

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

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

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

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

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

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

• **Notice of Appeal Determination**

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

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

**EXTERNAL REVIEW RIGHTS**

If you receive an Adverse Benefit Determination, you may have a right to have our decision reviewed by independent health care professionals who have no association with us if our decision involved making a judgment as to the Medical Necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment. The request for an external review by an Independent Review Organization (IRO) must be submitted within four months after you receive notice of the internal appeal determination. You or your authorized representative may file a request for external review by completing the required forms and submitting them directly to the address noted below. We will also provide the forms to you upon request.
For a standard external review, a decision will be made within 45 days of receiving your request. If you have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed, you may be entitled to request an expedited external review of our denial. If our denial to provide or pay for a health care service or course of treatment is based on a determination that the service or treatment is Experimental or Investigational, you also may be entitled to file a request for external review of our denial.

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

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

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

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

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

President of Blue Cross and Blue Shield of Oklahoma
Notice concerning reconstructive surgery benefits

Your health plan provides coverage for certain reconstructive procedures relating to a covered mastectomy. For a covered person receiving benefits in connection with a mastectomy, the following treatments will be covered, as they are determined necessary by the attending physician and the patient:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of the mastectomy, including lymphedema

These benefits will be provided subject to the same deductible and coinsurance applicable to other medical and surgical benefits provided under your plan. For more information concerning your mastectomy-related benefits, call the phone number on your ID card.

Oklahoma State law requires the following minimum for inpatient hospital services related to breast cancer and other breast conditions:

- Not less than 48 hours of inpatient care following a mastectomy
- 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 inpatient hospital stay when the attending physician, in consultation with the patient, determines that a shorter hospitalization is appropriate.