Your Health Care Benefits Program

For Employees of

Sheet Metal Workers' Local 270 Welfare Fund

Blue Choice

Effective February 1, 2018

Administered by:

BlueCross BlueShield of Oklahoma

SHEET METAL | AIR | RAIL | TRANSPORTATION
SMART

70261.0115

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Plan Summary

Sheet Metal Workers' Local 270 Welfare Fund (called the ***Plan Administrator***) has established and maintains a self-insured Plan of Comprehensive Health Care Benefits (called the ***Plan***) for its eligible Members and other persons as designated in its personnel policy.

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

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

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

This benefit booklet is issued according to the terms of the Plan. All statements in this benefit booklet are subject to other terms of the Plan document on file at the Union Local.

This benefit booklet replaces any and all summaries, certificates or benefit booklets previously issued for the Members under the Plan. It describes the Plan in effect as of February 1, 2018, for all Covered Persons (called "you" or "your").

Important Information

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

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

YOUR PARTICIPATING PROVIDER NETWORK

Your coverage is a Preferred Provider Organization (PPO) plan that offers a wide choice of network doctors and Hospitals. 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 coverage will provide the highest level of Benefits if you use a Network Provider.

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

HOW YOUR COVERAGE WORKS

Your coverage is designed to give 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 Network Provider.

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

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

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

COST SHARING FEATURES OF YOUR COVERAGE

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

Selecting a Provider

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

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

The BlueCard® Program

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

- **Finding a Physician or Hospital**

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

- **Available Care Coast to Coast**

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

- **Remember to Always Carry the BlueCard**

  Make sure you always carry your Identification Card — The BlueCard. And be sure to use Blue Cross and Blue Shield Physicians and Hospitals whenever you'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, Copayment and/or Coinsurance amounts whenever it is necessary so that they may obtain a Provider discount for you on Covered Services you receive outside the state of Oklahoma.

How The BlueCard Program Works

- You're outside the state of Oklahoma and need health care.
- Call 1-800-810-BLUE (2583) for information on the nearest participating Physicians and Hospitals, or visit the BlueCard Web site at http://www.bluecares.com.
- You are responsible for Preauthorization from Blue Cross and Blue Shield of Oklahoma.
- Visit the participating Physician or Hospital and present your Identification Card.
- The participating 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, Copayment and/or Coinsurance payments, if any.
- All participating Physicians and Hospitals are paid directly.

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 coverage 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.**

Preauthorization

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

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

If you utilize a Network Provider for Covered Services, that Provider ***may*** request Preauthorization for the services. However, it is the Covered Person's responsibility to assure that the services are Preauthorized before receiving care. You or your Provider may request Preauthorization by calling the Preauthorization number shown on your Identification Card before ***receiving*** treatment.

- **Preauthorization Process for Inpatient Services**

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

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

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

issuers may not, under federal law, require that a Provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

- **Preauthorization Process for Inpatient Psychiatric Care Services**

  All **Inpatient** services related to treatment of Mental Illness (including severe Mental Illness), drug addiction, substance abuse or alcoholism must be Preauthorized by the Claims Administrator.

- **Preauthorization Requests Involving Emergency Care**

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

- **Preauthorization Process for Certain Outpatient Services**

  You must request Preauthorization from the Plan at least two business days prior to receiving any of the following **Outpatient** services

  — Hospice Services;

  — Home Health Care Services;

  — Private Duty Nursing Services; and

  — Molecular genetic testing

  — Radiation Therapy

  — Diagnostic studies for obstructive sleep apnea;

  — Any of the following Psychiatric Care Services:

  — Psychological testing;

  — Neuropsychological testing;

  — Electroconvulsive therapy;

  — Intensive Outpatient Treatment;

  — Repetitive Transcranial Magnetic Stimulation.

  If you fail to request Preauthorization, your Benefits under this Group Health Plan may be reduced, as described below under *"Failure to Preauthorize"*.

- **Failure to Preauthorize**

  If the Covered Person does not call Preauthorization for the services listed above, except Molecular genetic testing. Applied Behavior Analysis and Psychiatric Care Services, these services will be subject to a $500 reduction in Benefit if, upon receipt of a claim, it is determined by the Claims Administrator that services were Medically Necessary. If it is determind that the services were not Medically Necessary or wre Experimental, Investigational and/or Unproven, it may be the Covered Person's responsibility to pay the full cost of the services received.

  If the Covered Person fails to obtain Preauthorization for Molecular genetic testing, Applied Behavior Analysis and Psychiatric Care Services :

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

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

Please keep in mind that any treatment you receive which is not a Covered Service under this Group Health Plan, or is not determined to be Medically Necessary, will be excluded from your Benefits. This applies even if Preauthorization approval is requested or received.

- **Response to Preauthorization Requests**

  The Claims Administrator will provide a written response to your Preauthorization request no later than 15 days following the date they receive your request. This period may be extended one time for up to 15 additional days, if the Claims Administrator determines that additional time is necessary due to matters beyond its control.

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

  If an extension of time is necessary due to the need for additional information, the Claims Administrator will notify you of the specific information needed, and you will have 45 days from receipt of the notice to provide the additional information. The Claims Administrator will provide a written response to your request for *Preauthorization* within 15 days following receipt of the additional information.

  The procedure for appealing an adverse Preauthorization determination is set forth in the section entitled, ***Complaint/Appeal Procedure***.

- **Response to Preauthorization Requests Involving Urgent Care**

  A "*Preauthorization Request Involving Urgent Care*" is any request for Medical Care or treatment with respect to which the 15-day review period set forth above:

  — could seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function; or

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

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

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

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 Claims Administrator 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 Inpatient Urgent Care or an ongoing course of treatment, the Claims Administrator will make a determination on the request/appeal as soon as possible (taking into account medical exigencies) but no later than 72 hours after it receives the initial request, or within 48 hours after it receives the missing information (if the initial request is incomplete).

What To Do In An Emergency

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

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

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

Allowable Charge

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

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

REMEMBER ...

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

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

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

  The Non-Contracting Allowable Charge is developed from base Medicare reimbursements, excluding any Medicare adjustments using information on the claim, and adjusted by a predetermined factor established by the Plan. Such factor will not be less than 100% of the base Medicare reimbursement rate.

  For services for which a Medicare reimbursement rate is not available, the Allowable Charge for Non-Contracting Providers will represent an average contract rate for network Providers adjusted by a

predetermined factor established by the Claims Administrator and updated on a periodic basis. Such factor shall not be less than 100% of the average contract rate and will be updated not less than every two years. The Claims Administrator will utilize the same claim processing rules and/or edits that it utilizes in processing Participating Provider claims for processing claims submitted by Non-Contracting Providers which may also alter the Allowable Charge for a particular service. In the event the Claims Administrator does not have any claim edits or rules, the Claims Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the claims. The Allowable Charge will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific claim, including but not limited to, disproportionate share and graduate medical education payments.

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

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

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

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

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

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

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

- When Covered Services are received outside the state of Oklahoma from a Provider who does not have a written agreement with Blue Cross and Blue Shield of Oklahoma or with the local Blue Cross and Blue Shield Plan, the "Allowable Charge" will be determined by the Blue Cross and Blue Shield Plan (Host Plan) servicing the area. Please refer to *"Benefits for Services Outside the sate of Oklahoma"* in the ***General Provisions*** section for additional information.

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

- Charges for any services which are not covered under your Plan.
- Any Deductible, Copayment and/or Coinsurance amounts that are applicable to your coverage *(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.

SPECIAL NOTICES

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

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

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

Identification Card

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

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

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

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

Designating an Authorized Representative

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

Questions

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

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

Or you can write:

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

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

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

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; and
- How and when your coverage stops under the Plan.

RULES OF ELIGIBILITY

- Eligibility for Coverage

  All Employees of contributing Employers, whose employment is subject to a collective bargaining agreement between the Sheet Metal Workers' International Association Local 270 and the SMACNA of Oklahoma Inc.

- Eligible Coverages

  Journeymen/Apprentice Employees and Helpers, who satisfy all eligibility requirements will be eligible for the Comprehensive Medical Plan, Life and Accidental Death and Dismemberment Plan, the Prescription Drug Plan, Vision Care Plan, Short Term Disability Plan Hearing Aid Benefit and the Employee's Assistance Program.

- Initial Eligibility

  If an Employee is not currently eligible, they will become eligible for benefits on the first day of the second month following the completion of six (6) or fewer consecutive calendar months in which they have worked 800 hours.

For example, if an Individual began work in January and had 140 hours for each of the next six months (800 total hours), they would become eligible for coverage on August 1, as illustrated in the chart below:

The Month in Which an Individual Has Completed 800 Hours of Consecutive Work Within 6 Consecutive Months	Effective Date of Coverage Assuming Adequate Hours are Maintained
June	August 1
July	September 1
August	October 1
September	November 1
October	December 1
November	January 1
December	February 1
January	March1
February	April 1
March	May 1
April	June 1
May	July 1

Special Note: If an employee is hospitalized because of injury or sickness before the date they would otherwise become insured, they will become insured on the date they are physically able and available to return to work.

CONTINUED ELIGIBILITY

Continued Eligibility will require 140 hours work each month. All of the hours of covered employment are accumulated in an hour bank. Withdrawals from the Reserve Hour Bank are made as follows:

- 140 hours each month for the first six months during which an individual is qualifying for eligibility as described above.
- 140 hours at the beginning of each following month, continuing as long as there are at least 140 hours available in their Reserve Hour Bank to meet the next coverage month.

Employment	Hours Worked	Withdrawal	Reserve Hour Bank*	Coverage Month
January	160			Ineligible
February	160			Ineligible
March	160			Ineligible
April	160			Ineligible
May	160	800	0	July
June	160	140	20	August
July	160	140	40	September
August	160	140	60	October
September	160	140	80	November
October	160	140	100	December
November	160	140	120	January
December	160	140	140	February

After an individual has become initially eligible for insurance, they will be allowed to accumulate excess hours in their Reserve Hour Bank up to a maximum of 1,200 hours.

DISABILITY PROVISION

If, after an individual becomes eligible and is unable to perform work because of a certified disability, they will be credited, for the purpose of maintaining eligibility, with twenty (20) Disability Hours for each full week of such disability for a lifetime maximum of thirty-six (36) weeks.

A certified disability is one for which an individual can submit evidence that they are drawing Workers' Compensation Benefits as the result of a disability which was incurred while performing work within the jurisdiction of Local Union No. 270.

Any individual with a certified disability as of November 3, 2015 will be subject to the terms of the Disability Provision as revised.

TERMINATION OF COVERAGE

Coverage will terminate on the earlier of (1) the end of the Coverage Month during which the hours in the Reserve Hour Bank fall below 140 after deduction for that Coverage Month's coverage; or (2) the date of such Individual's actual induction into the Armed Forces.

REINSTATEMENT OF ELIGIBILITY

If an individual's eligibility has terminated, they will again become covered if their Reserve Hour Bank shows a total of at least 600 hours within any consecutive 12-month period. Such reinstatement will be effective on the first day of the month following a thirty-day interval from the month in which this requirement is met. If they are not reinstated within the stipulated time period, their Reserve Hour Bank hours will be forfeited and the stated requirement will once again have to be met within the stated time frame.

**After an individual has become initially eligible for coverage, they will be allowed to accumulate excess hours in their Reserve Hour Bank up to a maximum of 1,200 hours.*

SERVICE IN THE ARMED FORCES

If you are on a uniformed services leave (such as active or inactive duty training or active duty service in the United States Armed Forces, National Guard, Coast Guard or Public Health Service) for 31 days or less, you will continue to receive health care coverage for up to 31 days, in accordance with the Uniformed Services Employment and Re-Employment Rights Act of 1994 (USERRA).

If you are on uniformed services leave for more than 31 days, USERRA permits you to continue medical coverage for yourself and your Dependents at your own expense for up to 24 months. This continuation right operates in the same way as COBRA Coverage. In addition, your Dependent(s) may be eligible for health care coverage under TRICARE (previously known as the Civilian Health & Medical Program of the Uniformed Services or CHAMPUS). This Plan will coordinate coverage with TRICARE/CHAMPUS.

Coverage will not be offered for any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services. The uniformed services and the Department of Veterans Affairs will provide care for service-connected disabilities.

When you are discharged (not less than honorably) from "service in the uniformed services," your full eligibility will be reinstated as follows:

- On the day you make application to return to work with an Employer provided that you make application within 90 days from the date of discharge if the period of service was more than 180 days; or
- On the day you make application to return to work with an Employer provided that you make application 14 days from the date of discharge if the period of service was 31 days or more but less than 180 days; or
- On the date you return to work, provided that you return to work at the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional eight hours) if the period of service was less than 31 days.

If you are hospitalized or convalescing from an injury caused by uniformed service, these time limits are extended up to two years.

Regardless of whether or not you elect to continue the coverage provided by the Plan on a self- payment basis, your Hour Bank Account will be frozen until your return to work in Covered Employment, provided you make application to return to work or return to work as described above. If you do not make application to return to work or return to work within the above time periods, all hours in your Hour Bank Account will be forfeited.

ACTIVE EMPLOYEES, ~~, Widows and Retirees~~

Participation

If an individual has satisfied the initial Eligibility requirements and later becomes ineligible due to insufficient hours of Covered Employment, they may continue their eligibility for the month they would otherwise lose eligibility by making self-payments, in the amount equal to the current total hourly contribution rate multiplied by 140 hours. Such amount must be received by the Fund Office not later than the third (3^{rd}) business day of the month to be eligible for coverage for that month. An individual may make self-payment for a maximum of three (3) months during any twelve (12) month period. The individual has (31) business days from their initial date of self-payment eligibility in order to pay the first self-pay premium.

Termination of Self-Payment

If the required self-payment is not made within the specified time, eligibility will terminate. To requalify for coverage, an individual must satisfy the requirements noted in either the Reinstatement of Eligibility or Initial Eligibility section above.

Self — Payment Provision — Retirees

Retirees and eligible dependents may continue medical coverage until both retiree and spouse reach age 65. Retirees may not continue Accidental Death and Dismemberment coverage. Life Insurance may be continued until age 65. Medical rates and Life rates are to be determined by the Trustees. Retiree rates upon initial retirement will not increase.

Widows of Active Employees

Surviving spouses of an Active Employee may use the hours, if any, in the Employee's Reserve Hour Bank or make a Self-payment, in the amount equal to the current total hourly contribution rate multiplied by 140 hours, (or a combination of using the hour bank and self-payment) to maintain medical coverage for a period not to exceed 60 days, unless one of the following events occur earlier:

1. The surviving spouse reaches age 65;

2. The surviving spouse remarries; or

3. The surviving spouse becomes eligible for coverage under another group health plan."

Journeymen/Apprentice Employees of Newly Organized Contributing Employers

Journeymen/Apprentice employees of newly organized shops that become signatory on or after December 1, 1996 will become eligible in the manner set out in the rules of eligibility as stated below:

All Journeymen/Apprentice employees of newly organized contributing employers whose employment is subject to a collective bargaining agreement between the Sheet Metal Workers' International Association Local 270 and SMACNA of Oklahoma, employed on the date the union agreement is signed will acquire coverage under the following rules of eligibility:

An employee must be actively working at the time of the employee's initial eligibility.

If an employee is not actively at work on the date of initial eligibility, but the employee would otherwise be eligible for coverage, the employee's eligibility will begin on the 1st day of the month following the employee's return to work.

An Individual Journeyman/Apprentice employed after the date the union agreement is signed by the newly organized shop must meet the normal eligibility requirements, as stated in the master insurance policy. This woruld apply to transfers from another signatory shop or new employees of the newly organized shop after the agreement is signed.

- If a newly organized shop signs the union agreement on the 1st day of the month, their Journeymen/Apprentice employees are eligible to participate in the group insurance plan on the 1st day of the following month.

  Example: Signed 11/01 — Eligible 12/01

- If a newly organized shop signs the union agreement in the middle of the month, their Journeymen/Apprentice employees are eligible to participate in the group insurance plan on the 1st day of the second month.

  Example: Signed 12/15 - Eligible 02/01

- Journeymen/Apprentice employees of newly organized shops insurance will be provided regular Journeymen/Apprentice Class Medical/Life/AD&D/EAP, Short Term Disability, Vision Care and Prescription Card Coverage, as stated in the Plan Documents/Master Policy(ies).

If the union agreement with the newly organized shop is signed on the 1st day of the month, coverage will be provided on the 1st day of the next month. Coverage for eligible Journeymen/Apprentice employees will continue for an additional month (1) when the member has 140 hours or more reported in the first month of covered employment; or (2) the Health & Welfare Fund will provide an additional month of coverage to eligible Journeymen/Apprentice employees who do not have 140 hours work reported in the first month of covered employment. The first month the Journeymen/Apprentice employee has work hours reported, the Fund will deduct 140 hours from the reported hours, or if the Journeyman/Apprentice employee has less than 140 hours reported, the Fund will deduct the total hours reported. Any work hours reported in excess of 140 hours per month will accumulate in a reserve hour bank, for that Journeyman/Apprentice member, up to a maximum of 1,200 hours, per the group insurance master plan. The 3rd month and thereafter, of Journeymen/Apprentice coverage, will be dependent upon a minimum of 140 hours.

Example: November work hours reported pays January insurance coverage; no work hours reported in December, lose coverage February 1. Back to work February 15, coverage effective May 1, if there are 140 hours or more reported.

CONTRIBUTING CONTRACTOR EMPLOYERS AND THEIR ELIGIBLE FULL-TIME NON-BARGAINED EMPLOYEES

Non-bargained employees of Contributing Employers who are members of the Sheet Metal and Air-Conditioning Contractors National Association, Inc. (SMACNA) who have a written collective bargaining agreement with the Sheet Metal Workers International Association Local 270, may become eligible for coverage for medical benefits, Dental, Life and Accidental Death and Dismemberment Insurance, and the Prescription Drug Program, subject to the following rules of eligibility.

- Contributing Employers and their eligible full–time non-bargained employees must be **actively working** at the time of the employer/employee's initial eligibility.

- If an employer/employee is not actively at work on the date of initial eligibility, but the employee would otherwise be eligible for coverage, the employee's eligibility will begin on the 1st day of the month following the employee's return to work.

- The 800 hour eligibility qualification ruling will not apply, and the non-bargained employee will not accumulate any excess bank hours, and, as such, will not be eligible for the Vision Care Plan or the Short Term Disability Plan.

- Eligibility for non-bargained employees' coverage will be based on 150 hours per month, each and every month. Coverage will cease on the 1st of the month following cessation of their employment with the Contributing Employer or upon failure of the Contributing Employer to make payment for contributions due in order to remain insured under the plan.

- Initial advance premium payment is to be paid to the Fund prior to the month in which the SMACNA Contractor and their eligible full–time non-union employees enroll in the Plans. Monthly premium payments will be due on or prior to the 10th of each and every month, in the form of a check payable to SMW Local 270 Welfare Fund. Monthly premium payments for the Prescription Drug Plan will be made payable to the SMW Local 270 Rx Account.

- The Contributing Employer will pay contributions based on 150 hours for each person to be covered for both the Health & Welfare and the Prescription Drug Plans, which is to be the same contribution rate paid for bargained employees.

- Participation is conditioned upon the Contributing Employer signing of a Non-Bargaining Unit Participation Agreement.

Conditions and Effective Date

Coverage will take effect for an Eligible Person and his/her Dependents on the date the Eligible Person is eligible for coverage: A person may not be covered as both an Member and as a Dependent. If he/she qualifies as both, then he/she may be covered only as a Member and not as a Dependent.

An Eligible Person may refuse coverage. The refusal must be in writing to the Plan Administrator on forms provided by the Plan Administrator. If the Eligible Person later wants coverage, he/she may Enroll with an effective date of February 1st.

Before retiree coverage will be effective, the retiree must agree to pay the premium and make written request to the Plan Administrator. The request must be on forms provided by the Plan Administrator for that purpose. If he/she does these things, the retiree's coverage will take effect as follows:

- On the date the retiree becomes eligible, if request is made on or before such date; or
- On the date of request, if the request is made within 31 days after the retiree's eligibility date.

Who Is an Eligible Person

You are an Eligible Person if you satisfy the eligibility requirements specified by your Plan Administrator, as set forth in the Plan.

Coverage will take effect for an Eligible Person and his/her Dependents on the date the Eligible Person is eligible for coverage. A person may not be covered as both an Member and as a Dependent. If he/she qualifies as both, then he/she may be covered only as an Member and not as a Dependent.

An Eligible Person may refuse coverage. The refusal must be in writing. If the Eligible Person later wants coverage, he/she may Enroll with an effective date of February 1st.

Before retiree coverage will be effective, the retiree must agree to pay the contribution and make a written request. If he/she does so, the retiree's coverage will take effect as follows:

- On the date the retiree becomes eligible, if request is made on or before such date; or
- On the date of request, if the request is made within 31 days after the retiree's eligibility date.

Retirees and eligible Dependents may continue medical coverage until both retiree and spouse reach age 65.

If an individual's eligibility has terminated, they will again become covered if their Reserve Hour Bank shows a total of at least 600 hours within any consecutive 12-month period. Such reinstatement will be effective on the first day of the month following a thirty-day interval from the month in which this requirement is met.

If they are not reinstated within the stipulated time period, their Reserve Hour Bank hours will be forfeited and the stated requirement will once again have to be met within the stated time period.

Who Is an Eligible Dependent

An Eligible Dependent is defined as:

- your spouse.
- your natural child, a stepchild, an adopted child or child Placed for Adoption (including a child for whom you or your spouse is a party in a legal action in which the adoption of the child is sought), under 26 years of age,

regardless of presence or absence of a child's financial dependency, residency, student status, employment status, marital status, eligibility for other coverage or any combination of those factors.

A child not listed above who is legally and financially dependent upon the Covered Person or spouse is also considered a Dependent child under the Group Health Plan, provided proof of dependency is provided with the child's application.

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

— Dependent children who are medically certified as disabled and dependent upon you or your spouse are eligible for coverage regardless of age, provided the disability began before the child attained the age of 26.

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

How to Enroll

To be covered under the Plan, you must complete the enrollment process outlined by your Human Resources Department.

Initial Enrollment Period

- **Initial Group Enrollment**

  If you are an Eligible Person on the Plan Effective Date and your application for coverage is received during the Initial Enrollment Period, the Effective Date for you and your Eligible Dependents (if applicable) is the Plan's Effective Date.

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

  If you become an Eligible Person after the Plan's Effective Date and your application is received within 31 days of being first eligible, the Effective Date for you and your Eligible Dependents (if applicable) will be the date you become eligible.

- **Initial Enrollment of New Dependents**

  You can apply to add Dependents to your coverage by submitting an application 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 Plan, then the following rules apply:

    ○ If you are enrolled under Member Only (Single) Coverage, you may add coverage for a newborn effective on the date of birth. However, your application must be received within 31 days of the child's birth.

    ○ If you are enrolled under Member and Spouse Only Coverage (if applicable), coverage for the newborn will be effective on the date of birth however your application must be received within 31 days of the child's birth.

    ○ If you are enrolled under Member and Children Coverage, Member, Spouse and Children Coverage or Family Coverage, you must notify the Plan in writing of the child's birth within 31 days. The Effective Date for the newborn will be the child's birth date.

- If you choose not to Enroll your newborn child, coverage for that child will be included under the mother's maternity Benefits (provided the mother is enrolled under this Plan) for 48 hours following a vaginal delivery, or 96 hours following a cesarean section.

IMPORTANT:

To expedite the handling of your newborn's claims, please make sure your application (including your child's name and birth date) is received 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 application 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

The Plan includes Special Enrollment Periods during which individuals who previously declined coverage are allowed to Enroll (without having to wait until the next Open Enrollment Period). A Special Enrollment Period can occur if a person with other health coverage loses that coverage or if a person becomes a Dependent through marriage, birth, adoption or Placement for Adoption. A person who Enrolls during a Special Enrollment Period is not treated as a late enrollee.

- **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 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 Court-Ordered Dependent Coverage**

An Eligible Dependent is not considered a late enrollee if the Member's application to add the Dependent is received within 31 days after issuance of a court order requiring coverage be provided for a spouse or minor or Dependent child under the Member's coverage. The Effective Date will be determined by the Plan in accordance with the provisions of the court order.

- **Special Enrollment Related to Medicaid and Child Health Insurance Program (CHIP) Coverage**

A 60-day Special Enrollment Period occurs when Members and Dependents who are eligible but not enrolled for coverage in the Group Health Plan experience either of the following qualifying events:

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

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

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

Open 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 during the next Open Enrollment Period. An Open Enrollment Period will be held each year during the 31–day period immediately before the Plan Anniversary (renewal date). 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 Group Health Plan on behalf of your children. An order or notice issued through a state administrative process that has the force of law may also provide for such coverage and be a QMCSO.

The order must include specific information such as:

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

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

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

Deleting a Dependent

You can change your coverage to delete Dependents. You can also change from Family Coverage to Single Coverage. The change will be effective at the end of the coverage period during which your contributions have been made, except in the case of divorce, where the change will be effective the date the divorce is granted.

COBRA Continuation Coverage

THIS PROVISION MAY NOT APPLY TO YOUR PLAN'S COVERAGE. PLEASE CHECK WITH YOUR GROUP ADMINISTRATOR TO DETERMINE IF YOUR PLAN IS SUBJECT TO COBRA* REGULATIONS.

** Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.*

- **Eligibility for Continuation Coverage**

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

  You or your Eligible Dependent is responsible for notifying the Plan Administrator 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 Plan Administrator notifies you, or your Eligible Dependent, of your COBRA Continuation Coverage rights.

- **COBRA Continuation Coverage Period**

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

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

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

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

    ○ the ineligibility of a Dependent child;

    provided the 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 Plan Administrator 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 Plan Administrator within 30 days after the Social Security Administration makes a determination that you or your Dependent is no longer disabled.

- **Multiple Qualifying Events**

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

- **Special TAA/ATAA Election Period**

  An Member who loses his/her job due to a trade-related reason may be entitled to a second 60-day COBRA election period if the Member 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 Member 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 Member becomes eligible for trade adjustment assistance, as determined by the Department of Labor or state labor agency. The Member is not eligible for the special election period if the TAA/ATAA eligibility determination is made more than six months after termination of employment.

When Coverage Under This Plan Ends

Coverage will stop at the end of the month in which an individual ceases to meet the definition of an Eligible Person or Eligible Dependent.

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

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

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

— the date on which the Plan Administrator stops providing any Group Health Plan to any Member;

— the date on which coverage stops because of a Covered Person's failure to pay any contribution required for the COBRA Continuation Coverage;

— the date on which the Covered Person first becomes (after the date of the election) covered under any other Group Health Plan which does not contain any exclusion or limitation with respect to a preexisting condition applicable to the Covered Person (or the date the Covered Person has satisfied the preexisting condition exclusion period under that plan); or

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

Your coverage will terminate retroactive to your Effective Date if you commit fraud or intentional misrepresentation of material fact 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.

BlueChoice Schedule of Benefits for Comprehensive Health Care Services

This schedule shows the Deductibles and/or Coinsurance amounts that apply to Covered Services described in the ***Comprehensive Health Care Services*** section of your benefit booklet. **Please note that services must be Medically Necessary, as determined by the Plan, in order to be covered.**

BENEFIT PERIOD	Calendar Year
NETWORK PROVIDERS	To receive maximum Benefits under the Plan, you must receive services from BlueChoice Providers in Oklahoma or BlueCard Providers outside the state of Oklahoma. Refer to www.bcbsok.com or call a Customer Service Representative at the number shown on your Identification Card to find a Network Provider near you.
DEDUCTIBLE	
Benefit Period Deductible	**Network Provider Services** — $200 per Benefit Period per Covered Person or $600 for all covered family members combined. **Out-of-Network Provider Services** — $750 per Benefit Period per Covered Person or $2,250 for all covered family members combined. Deductible amounts for Network Provider Services and Out-of-Network Provider Services **do** cross-apply. If two or more Covered Persons incur expenses for Covered Services as a result of injuries received in the same accident, only one Deductible will be applied to the aggregate of such charges. The Benefit Period Deductible applies to all Covered Services, except: • Routine Nursery Care (within first five days in-Network or Out-of-Network). • Outpatient Surgical Services (facility and Professional Surgery Services). • Outpatient Preadmission and Preoperative Testing. • Second Surgical Opinion. • Covered immunizations. • Routine colonoscopy.

OUT-OF-POCKET LIMIT

- **Network Provider Services** — When you have paid $3,000 per Covered Person or $9,000 for all covered family members combined (in excess of any Deductible amounts) for Covered Services provided by Network Providers during a Benefit Period, the amount of Allowable Charges covered by the Plan on behalf you and/or your Dependents will increase to 100% during the remainder of the Benefit Period for Covered Services you and/or your Dependents receive from Network Providers.

- **Out-of-Network Provider Services** — When you have paid $7,500 per Covered Person or $22,500 for all covered family members combined (in excess of any Deductible amounts) for Covered Services provided provided by Out-of-Network Providers during a Benefit Period, the amount of Allowable Charges covered by the Plan on behalf of you and/or your Dependents will increase to 100% during the remainder of the Benefit Period for Covered Services you and/or your Dependents receive from Out-of-Network Provider services.

Out-of-Pocket Limits for Network Provider Services and Out-of-Network Provider Services **do** cross-apply.

The Out-of-Pocket Limit and Benefit percentage amount specified above do not include any of the following:

- Services, supplies or charges limited or excluded by the Plan.

- Expenses not covered because a Benefit maximum has been reached.

- Any penalty incurred due to your failure to follow the Claims Administrator's requirements for Preauthorization, as set forth elsewhere in this benefit booklet.

- Charges in excess of the Allowable Charge.

- Deductibles.

BENEFIT PERCENTAGE

The following chart shows the percentage of Allowable Charges covered by the Plan through payments and/or contractual arrangements with Providers. These percentages apply only after the Deductible amount have been satisfied.

COVERED SERVICES (Subject to the *Comprehensive Health Care Services* section which follows)	BENEFIT PERCENTAGE AMOUNT Network Provider Services	Out-of-Network Provider Services
HOSPITAL SERVICES*	90%	70%
SURGICAL/MEDICAL SERVICES		
Physicians' Office Visits	90%	70%
All Other Covered Surgical/Medical Services	90%	70%
OUTPATIENT DIAGNOSTIC SERVICES	90%	70%
Routine Colonoscopy	100%	100%
OUTPATIENT THERAPY SERVICES Maximum of 25 Outpatient visits for Physical Therapy and no maximum for Occupational Therapy and Speech Therapy per Benefit Period	90%	70%
MATERNITY SERVICES	90%	70%
MASTECTOMY AND RECONSTRUCTIVE SURGICAL SERVICES	90%	70%
HUMAN ORGAN, TISSUE AND BONE MARROW TRANSPLANT SERVICES*	90%	70%
AMBULATORY SURGICAL FACILITY SERVICES**	100%	100%
PSYCHIATRIC CARE SERVICES	90%	70%
AMBULANCE SERVICES	90%	90%
REHABILITATION CARE*** 30-day maximum per Benefit Period	90%	70%
SKILLED NURSING FACILITY SERVICES*** 30-day maximum per Benefit Period	90%	70%
HOME HEALTH CARE SERVICES*** 30-visit maximum per Benefit Period	90%	70%

** Inpatient Hospital services are subject to Preauthorization approval from the Claims Administrator. See the **Important Information** section regarding "Preauthorization" requirements.*

*** For anesthesia, lab and radiology, the percentage is reduced to the general payment level 90%/70%.*

**** Subject to Preauthorization approval from the Plan. See the **Important Information** section for details regarding "Preauthorization" requirements.*

COVERED SERVICES (Subject to the *Comprehensive Health Care Services* section which follows)	BENEFIT PERCENTAGE AMOUNT	
	Network Provider Services	Out-of-Network Provider Services
HOSPICE SERVICES* 60-visit maximum per Benefit Period	90%	70%
TEMPOROMANDIBULAR JOINT SYNDROME/DYSFUNCTION	90%	70%
DENTAL SERVICES FOR ACCIDENTAL INJURY	90%	70%
DIABETES EQUIPMENT, SUPPLIES AND SELF-MANAGEMENT SERVICES	90%	70%
DURABLE MEDICAL EQUIPMENT	90%	70%
PROSTHETIC APPLIANCES	90%	70%
ORTHOTIC DEVICES Maximum of 75 per Benefit Period	90%	70%
ALL OTHER COVERED SERVICES	90%	70%

Subject to Preauthorization approval from the Plan. See the **Important Information section for details regarding "Preauthorization" requirements.*

Comprehensive Health Care Services

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

HOSPITAL SERVICES

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

- **Bed and Board**

  Bed, board and general nursing service in:

  — A room with two or more beds;

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

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

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

- **Ancillary Services**

  — Operating, delivery and treatment rooms;

  — Prescribed drugs;

  — Whole blood, blood processing and administration;

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

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

  — Oxygen;

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

  — Diagnostic Services;

  — Therapy Services.

- **Emergency Accident Care**

  Outpatient emergency Hospital services and supplies to treat injuries caused by an accident.

- **Emergency Medical Care**

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

- **Surgery**

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

- **Routine Nursery Care**

  — Inpatient Hospital Services for Routine Nursery Care of a newborn Covered Person.

  — Routine Nursery Care does not include treatment or evaluation for medical or surgical reasons during or after the mother's maternity confinement. In the event the newborn requires such treatment or evaluation while covered under the Plan:

    ○ the infant will be considered as a Covered Person in its own right and will be entitled to the same Benefits as any other Covered Person under the Plan; and

    ○ a separate Deductible will apply to the newborn's Hospital confinement.

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

SURGICAL/MEDICAL SERVICES

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

- **Surgery**

  Benefits include visits before and after Surgery.

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

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

    ○ the primary procedure; plus

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

  — Sterilization, regardless of Medical Necessity.

- **Assistant Surgeon**

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

- **Anesthesia**

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

- **Inpatient Medical Services**

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

— Inpatient Medical Care Visits

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.

[*] *A procedure performed at the same time as a primary surgical procedure, but which is clinically integral to the performance of the primary procedure, and is not reimbursed separately.*

— Newborn Well Baby Care

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

- **Outpatient Medical Services**

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

— Emergency Accident Care

Treatment of accidental bodily injuries.

— Emergency Medical Care

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

— Home, Office and Other Outpatient Visits

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

— Contraceptive Devices

Contraceptive devices which are:

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

— Preventive Care Services

Services performed by a Provider as “routine” or “screening” services, limited to the followng:

- one exam every two years for Covered Persons age 40 through 49; and
- one exam per Benefit Period for Covered Persons age 50 and over.

— Routine Gynecological/Obstetrical Examination and Pap Smear

Routine gynecological/obstetrical examination and Pap smear performed in the Physician's office, with no age limitation.

— Mammography

Radiological services include bilateral mammography screening (two view film study of each breast) for the presence of occult breast cancer, with no age limitation.

— Prostate Cancer Screening

Annual screening for the early detection of prostate cancer in male Covered Persons, including a prostate-specific antigen blood test and a digital rectal examination.

— Colorectal Cancer Screening

Colorectal cancer examinations, colonoscopies and laboratory tests for cancer screening for any nonsymptomatic Covered Person, in accordance with standard, accepted published medical practice guidelines.

— Routine immunizations, with no age limitation.

— Child Health Supervision 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 tests in keeping with prevailing medical standards.

Child Health Supervision Services must be rendered during a periodic review, provided by or under the supervision of a single Physician during the course of one visit.

— Bone Density Testing

Bone density testing when ordered or performed by a Physician or other Provider, with no age limitation.

OUTPATIENT DIAGNOSTIC SERVICES

- Radiology, Ultrasound and Nuclear Medicine
- Laboratory and Pathology
- ECG, EEG and Other Electronic Diagnostic Medical Procedures and Physiological Medical Testing, as determined by the Claims Administrator.

OUTPATIENT THERAPY SERVICES

- Radiation Therapy
- Chemotherapy

Outpatient Therapy Services do not include oral Chemotherapy or self-injectable/self-administered Chemotherapy.

- Respiratory Therapy
- Dialysis Treatment
- Physical Therapy

  Benefits for Outpatient Physical Therapy, (including visits to the Covered Person's home) are limited to the number of visits specified in the *Schedule of Benefits for Comprehensive Health Care Services*.

- Occupational Therapy

  Benefits for Outpatient Occupational Therapy (including visits to the Covered Person's home) are limited to the number of visits specified in the *Schedule of Benefits for Comprehensive Health Care Services*.

- Speech Therapy

  Benefits for and Outpatient Speech Therapy (including visits to the Covered Person's home) are limited to the number of visits specified in the *Schedule of Benefits for Comprehensive Health Care Services*.

Maternity Services

- Hospital Services and Surgical/Medical Services from a Provider (not including the services of midwives) for:
  - Normal Pregnancy

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

    Physical effects directly caused by pregnancy but which are not considered from a medical viewpoint to be the effect of normal pregnancy, including conditions related to ectopic pregnancy or those that require cesarean section.
  - Interruptions of Pregnancy
    - Miscarriage
    - Abortion, when the mother's life is endangered
- Covered Maternity Services include the following:
  - A minimum of 48 hours of Inpatient care at a Hospital, or a birthing center licensed as a Hospital, following a vaginal delivery for the mother and newborn infant who are covered under the Plan after childbirth, except as otherwise provided in this section; or
  - A minimum of 96 hours of Inpatient care at a Hospital following a delivery by cesarean section for the mother and newborn infant who are covered under the Plan after childbirth, except as otherwise provided in this section; and
  - Postpartum home care following a vaginal delivery if childbirth occurs at home or in a birthing center licensed as a birthing center. The coverage shall provide for one home visit within 48 hours of childbirth

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

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

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

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

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

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

MASTECTOMY AND RECONSTRUCTIVE SURGICAL SERVICES

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

- Inpatient Hospital Services for:

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

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

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

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

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

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

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

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

Human Organ, Tissue and Bone Marrow Transplant Services

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

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

- **Definitions**

  In addition to the definitions listed under the ***Definitions*** section, the following definitions shall apply and/or have special meaning for the purpose of this section:

  — **Bone Marrow Transplant**

    A medical and/or surgical procedure comprised of several steps or stages including:

    ○ the harvest of stem cells or progenitor cells, whether from the bone marrow or from the blood, from a third-party donor (allogeneic transplant) or from the patient (autologous transplant);

    ○ processing and/or storage of the stem cells or progenitor cells after harvesting;

    ○ the administration of High-Dose Chemotherapy and/or High-Dose Radiation Therapy, when this step is prescribed by the treating Physician;

    ○ the infusion of the harvested stem cells or progenitor cells; and

    ○ hospitalization, observation and management of reasonably anticipated complications such as graft versus host disease, infections, bleeding, organ or system toxicities and low blood counts.

The above definition of autologous Bone Marrow Transplant specifically includes transplants wherein the transplant component is derived from circulating blood in lieu of, or in addition to, harvested directly from the bone marrow, a procedure commonly known as peripheral stem cell or progenitor cell transplant or rescue procedure. This definition further specifically includes all component parts of the procedure including, without limitation, the High-Dose Chemotherapy and/or High-Dose Radiation Therapy.

— **High-Dose Chemotherapy**

A form of Chemotherapy wherein the dose exceeds standard doses of Chemotherapy to the extent that virtually all patients who receive High-Dose Chemotherapy sustain destruction of the bone marrow to the point that bone marrow or peripheral stem cells or progenitor cells must be implanted or infused to keep the patient alive.

— **High-Dose Radiation Therapy**

A form of Radiation Therapy wherein the dose exceeds standard doses of Radiation Therapy resulting in destruction of the bone marrow to the point that bone marrow or peripheral stem cells or progenitor cells must be implanted or infused to keep the patient alive.

— **Preauthorization**

The process that determines in advance the Medical Necessity or Experimental, Investigational and/or Unproven nature of certain care and services under the Plan. Preauthorization is subject to all conditions, exclusions and limitations of the Plan. Preauthorization does not guarantee that all care and services a Covered Person receives are eligible for Benefits under the Plan.

— **Procurement Services**

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

- **Transplant Services**
  - — Musculoskeletal transplants;
  - — Parathyroid transplants;
  - — Cornea transplants;
  - — Heart-valve transplants;
  - — Kidney transplants;
  - — Heart transplants;
  - — Single lung, double lung and heart/lung transplants;
  - — Liver transplants;
  - — Intestinal transplants;
  - — Small bowel/liver or multivisceral (abdominal) transplants;
  - — Pancreas transplants;

— Islet cell transplants; and

— Bone Marrow Transplants.

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

  — The transplant must meet the criteria established by the Claims Administrator for assessing and performing organ or tissue transplants, or Bone Marrow Transplant procedures, as set forth in the Claims Administrator's written medical policies.

  — In addition to the ***Exclusions*** set forth elsewhere in this benefit booklet, no Benefits will be provided for the following organ or tissue transplants or Bone Marrow Transplants or related services:

    ○ Adrenal to brain transplants.

    ○ Allogeneic islet cell transplants.

    ○ High-Dose Chemotherapy or High-Dose Radiation Therapy if the associated autologous or allogeneic Bone Marrow Transplant, stem cell or progenitor cell treatment or rescue is not a Covered Service.

    ○ Small bowel transplants using a living donor.

    ○ Any organ or tissue transplant or Bone Marrow Transplant from a non-human donor or for the use of non-human organs for extracorporeal support and/or maintenance.

    ○ Any artificial device for transplantation/implantation, except in limited instances as reflected in the Claims Administrator's written medical policies.

    ○ Any organ or tissue transplant or Bone Marrow Transplant procedure which the Claims Administrator considers to be Experimental, Investigational and/or Unproven in nature.

    ○ Expenses related to the purchase, evaluation, Procurement Services or transplant procedure if the organ or tissue or bone marrow or stem cells or progenitor cells are sold rather than donated to the Covered Person recipient.

    ○ All services, provided directly for or relative to any organ or tissue transplant, or Bone Marrow Transplant procedure which is not specifically listed as a Covered Service in the Plan.

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

- **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 applied to the recipient's coverage under the Plan.

— When only the living donor is a Covered Person, the donor is entitled to the Benefits of the Plan. The Benefits are limited to only those not provided or available to the donor from any other source. This includes, but is not limited to, other insurance coverage or other Blue Cross or Blue Shield coverage or any government program available to the recipient. There are no Covered Services for the non-Covered Person transplant recipient.

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

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

- **Research-Urgent Bone Marrow Transplant Benefits Within National Institutes Of Health Clinical Trials Only**

  Bone Marrow Transplants that are otherwise excluded by the Claims Administrator as Experimental, Investigational and/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

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

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

Psychiatric Care Services

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

- Inpatient Facility Services

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

- Inpatient Medical Services

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

— Medical Care visits, **limited to one visit or other service per day**;

— Individual Psychotherapy;

— Group Psychotherapy;

— Psychological Testing; and

— Convulsive Therapy Treatment.

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

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

- Outpatient Psychiatric Care Services

  — Facility and Medical Services

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

  — Day/Night Psychiatric Care Services

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

- Drug Addiction, Substance Abuse and Alcoholism

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

Ambulance Services

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

  — From your home to a Hospital;

  — From the scene of an accident or medical emergency to a Hospital;

  — Between Hospitals;

  — Between a Hospital and a Skilled Nursing Facility; or

  — From the Hospital to your home.

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

Rehabilitation Care

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

Benefits for Rehabilitation Care are limited to the number of visits specified in the *Schedule of Benefits for Comprehensive Health Care Services.*

Rehabilitation Care is subject to the *"Preauthorization"* requirements of the Plan (see *Important Information* section). Benefits for Rehabilitation Care if, upon receipt of a claim, Benefits are available under the Plan.

Skilled Nursing Facility Services

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

Benefits for Skilled Nursing Facility Services are limited to the number of visits specified in the *Schedule of Benefits for Comprehensive Health Care Services.*

Skilled Nursing Facility Services are subject to the *"Preauthorization"* requirements of the Plan (see *Important Information* section). Benefits for Skilled Nursing Facility Services if, upon receipt of a claim, Benefits are available under the Plan.

No Benefits are available:

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

Home Health Care Services

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

- Medical and surgical supplies;
- Prescribed drugs;
- Oxygen and its administration.

Benefits for Home Health Care Services are limited to the number of visits specified in the *Schedule of Benefits for Comprehensive Health Care Services.* Benefits are limited to the following:

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

Home Health Care is subject to the *"Preauthorization"* requirements of the Plan (see *Important Information* section). Benefits for Home Health Care if, upon receipt of a claim, Benefits are available under the Plan.

The Plan does not pay Home Health Care Benefits for:

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

Hospice Services

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

Benefits for Hospice Services are limited to the number of visits specified in the *Schedule of Benefits for Comprehensive Health Care Services.*

Hospice Services are subject to the *"Preauthorization"* requirements of the Plan (see *Important Information* section). Failure to comply with these requirements Benefits for Hospice Services, if, upon receipt of a claim, Benefits are available under the Plan.

Temporomandibular Joint Syndrome/Dysfunction

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

Dental Services for Accidental Injury

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

Diabetes Equipment, Supplies and Self-Management Services

- The following equipment, supplies and related services for the treatment of Type I, Type II and gestational diabetes when Medically Necessary and when recommended or prescribed by a Physician or other Provider:
  - — Blood glucose monitors;
  - — Blood glucose monitors to the legally blind;
  - — Test strips for glucose monitors;
  - — Visual reading and urine testing strips;
  - — 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 of which the only purpose are weight reduction) shall be limited to the following:

  — Visits Medically Necessary upon the diagnosis of diabetes;

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

  — Visits when reeducation or refresher training is Medically Necessary.

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

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

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

DURABLE MEDICAL EQUIPMENT

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

- It is used in the Covered Person's home, place of residence or dwelling;

- 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
- It is prescribed by a Physician and meets the Claims Administrator's criteria of Medical Necessity for the given diagnosis.

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

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

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

Prosthetic Appliances

Devices, along with pertinent supplies, which replace all or part of an absent body organ and which are Medically Necessary for the alleviation or correction of conditions arising out of bodily injury or illness covered by the Plan. Eyeglass lens, soft lens and contact lens are included if prescribed as part of postoperative treatment for cataract extraction. Implantation or removal of breast prostheses is a Covered Service only in connection with reconstructive breast Surgery performed solely and directly as a result of mastectomy which is Medically Necessary.

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

Orthotic Devices

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

Benefits will be provided for the following orthotic devices:

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

Not covered are:

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

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

Exclusions

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

WHAT IS NOT COVERED

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

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

— for the improvement of the physiological functioning of a malformed body member resulting from a congenital defect.

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

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

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

  — for the improvement of the physiological functioning of a malformed body member resulting from a congenital defect.

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

- For eyeglasses, contact lenses or examinations for prescribing or fitting them, except for:
  - — aphakic patients (including lenses required after cataract Surgery) and soft lenses or sclera shells to treat disease or injury; or
  - — Vision examinations performed in connection with the diagnosis or treatment of disease or injury.
- For eye Surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).
- For hearing aids, tinnitus maskers or examinations for prescribing or fitting them. Hearing examinations not related to the prescription or fitting of hearing aids will be a Covered Service only when performed in connection with the diagnosis or treatment of disease or injury or as specified under *"Preventive Care Services"*.
- For transsexual Surgery or any treatment leading to or in connection with transsexual Surgery.
- For diagnosis, treatment or medications for infertility and fertilization procedures. Examples include any form of: artificial insemination; ovulation induction procedures; in vitro fertilization; embryo transfer; or any other procedures, supplies or medications which in any way are intended to augment or enhance your reproductive ability.
- For treatment of sexual problems not caused by organic disease.
- For treatment of obesity, including morbid obesity, regardless of the patient's history or diagnosis, including but not limited to the following: weight reduction or dietary control programs; surgical procedures; prescription or nonprescription drugs or medications such as vitamins (whether to be taken orally or by injection), minerals, appetite suppressants, or nutritional supplements; and any complications resulting from weight loss treatments or procedures.
- For medication, drugs or hormones to stimulate growth.
- For Prescription Drugs.
- For or related to acupuncture, whether for medical or anesthesia purposes.
- For conditions related to hyperkinetic syndromes, learning disabilities, behavioral problems, intellectual disability or for Inpatient confinement for environmental change.
- For unspecified developmental disorders or autistic disease of childhood.
- For family or marital counseling.
- For hippotherapy, equine assisted learning or other therapeutic riding programs.
- For which the Provider of service customarily makes no direct charge to a Covered Person.
- For or related to transplantation of donor organs, tissues or bone marrow, except as specified under *"Human Organ, Tissue and Bone Marrow Transplant Services"*.
- For Physician standby services.
- For elective abortion, unless the life of the mother is endangered.
- For massage therapy, including but not limited to effleurage, petrissage and/or tapotement.
- For private duty nursing services.
- For chiropractic care or muscle manipulations/subluxation.

- For services rendered by midwives.
- Which are not specifically named as Covered Services subject to any other specific exclusions and limitations in this Plan.

The plan may, without waiving these *Exclusions*, elect to provide Benefits for care and services while awaiting the decision of whether or not the care and services fall within the Exclusion list above. If it is later determined that the care and services are excluded from your coverage, the Claims Administrator will be entitled to recover the amount we have allowed for Benefits under the Plan; see *"Plan's Right of Recoupment"* in the General Provisions section of this benefit booklet. You must provide to s all documents needed to enforce our rights under this provision.

General Provisions

This section tells:

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

Benefits to Which You Are Entitled

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

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

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

Prior Approval

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

Notice and Properly Filed Claim

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

Your Properly Filed Claim must be furnished to the Claims Administrator within 90 days after the end of the Benefit Period for which claim is made.

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

Limitation of Actions

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

Payment of Benefits

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

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

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

Benefits under this Plan will be based upon the Allowable Charge (as the Claims Administrator determines) for Covered Services. A Network Provider may collect any Deductible, Copayment and/or Coinsurance amounts applicable to your coverage, but you will not be responsible for any amount that exceed the Allowable Charges 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 Charges in addition to any Deductible, Copayment, and/or Coinsurance amounts which may apply.**

In some cases, Covered Services may be rendered by a Provider who has a Participating Provider Agreement with the Plan, but who is *not* a Network Provider. These Providers (called Blue Traditional Providers) have agreed to charge Plan Covered Persons no more than a "Maximum Reimbursement Allowance" for Covered Services. Covered Persons who use Blue Traditional Providers are responsible for amounts over the "Allowable Charges" *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

The Claims Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Arrangements". These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross and Blue Shield Association. Whenever you access Covered Services outside the state of Oklahoma, you will receive it from one of two kinds of Providers. Most Providers ("participating Providers") contract with the local Blue Cross and/or Blue Shield Licensee in that geographic area ("Host Blue"). Some Providers ("non-contracting Providers") do no contract with the Host Blue. We explain below how both types are paid.

- **BlueCard® Program**

  Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, the Plan will remain responsible for what is agreed to in the benefit booklet. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating Providers.

When you obtain health care services through BlueCard outside the state of Oklahoma, the amount you pay for Covered Services is calculated on the ***lower*** of:

- The billed charges for your Covered Services; or
- The negotiated price that the on-site Blue Cross and/or Blue Shield Licensee ("Host Blue") passes on to the Plan.

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

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

- **Non-Participating Providers Outside the Claims Administrator's Service Area**

  — **Liability Calculation**

In general, when Covered Services are provided outside the state of Oklahoma by non-contracting Providers, the amount(s) a Covered Person pays for such services will be calculated using the methodology described in the benefit booklet for non-participating Providers located inside our service area. You may be responsible for the difference between the amount that the non-participating Providers bills and the payment the Plan will make for the Covered Services as set forth in this paragraph. Payments for out-of-network emergency services are governed by applicable federal and state law.

If you need Emergency Care, the Plan will cover you at the highest level that federal regulations allow. You will have to pay for any charges that exceed the Allowable Charge as well as for any Copayments, Coinsurance, Deductibles and amounts that exceed any Benefit maximums. Federal or state law, as applicable, will govern payments for out-of-network emergency services.

EXCEPTIONS

In some exception cases, the Claims Administrator may, but is not required to, in its sole and absolute discretion negotiate a payment with such non-participating Provider on an exception basis. If a negotiated payment is not available, then the Claims Administratior may make a payment based on the lessor of:

- the amount calculated using the methodology described in this benefit booklet for non-participating Providers located inside our service area (described above); or
- the following;
    - for professional Providers, make a payment based on publicly available Provider reimbursement data for the same or similar professional services, adjusted for geographical differences where applicable; or
    - For Hospital or facility Providers, make a payment based on publicly available data reflecting the approximate costs that Hospitals or facilities have incurred historically to provide the same or similar service, adjusted for geographical differences where applicable, plus a margin factor for the Hospital or facility.

In these situations, you may be liable for the differences between the amount that the non-participating Provider bills and the payment the Plan will make for the Covered Services as set forth above.

— **Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees**

Federal or state laws or regulations may require a surcharge, tax or other fee that applies to Employer accounts. If applicable, the Claims Administrator will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

- **BlueCross Blue Shield Global Core**

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands (hereinafter "BlueCard service area"), you may be able to take advantage of the Blue Cross Blue Shield Global Core when accessing Covered Services. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although the Blue Cross Blue Shield Global Core assists you with accessing a network of Inpatient, Outpatient and professional Providers, the network is not served by a Host Blue. As such, when you receive care from Providers outside the BlueCard service area, you will typically have to pay the providers and submit the claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or Hospital) outside the BlueCard service area, you should call the Service Center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a Physician appointment or hospitalization, if necessary.

— **Inpatient Services**

In most cases, if you contact the Blue Cross Blue Shield Global Core Service Center for assistance, Hospitals will not require you to pay for covered Inpatient services, except for your Deductibles, Copayments, Coinsurance, etc. In such cases, the Hospital will submit your claims to the Service Center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for Covered Services.

You must contact the Claims Administrator to obtain Preauthorization for non-emergency Inpatient services.

— **Outpatient Services**

Physicians, Urgent Care centers and other Outpatient Providers located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for Covered Services.

— **Submitting a Blue Cross Blue Shield Global Core Claim**

When you pay for Covered Services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core International claim form and send the form with the Provider's itemized bill(s) to the Service Center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from the Claims Administrator, the Service Center or online at www.bcbsglobalcore.com. If you need assistance with your claims submission, you should call the Service Center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

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

Determination of Benefits and Utilization Review

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

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

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

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

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

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

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

COVERED PERSON/PROVIDER RELATIONSHIP

The choice of a Provider is solely yours.

Providers are not employees, agents or other legal representatives of the Plan or Claims Administrator.

The Plan does not furnish Covered Services but only provides Benefits for Covered Services you receive from Providers. The Plan are not liable for any act or omission of any Provider. The Plan has no responsibility for a Provider's failure or refusal to give Covered Services to you.

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

IDENTITY THEFT PROTECTION SERVICES

As a Covered Person, the Plan makes available at no additional cost to you identity theft protection services, including credit monitoring, fraud detection credit/identity repair and insurance to help protect your information. These identity theft protection services are currently provided by the Plan's designated outside vendor and acceptance or declination of these services is optional to you. Covered Persons who wish to accept such identity theft protection services will need to individually enroll in the program online at www.bcbsok.com. Services may automatically end when the person is no longer an eligible Covered Person. Services may change or be discontinued at any time with or without notice and the Plan does not guarantee that a particular vendor or service will be available at any given time.

COORDINATION OF BENEFITS

All Benefits provided under this benefit booklet are subject to this provision.

- **Definitions**

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

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

  — Group, blanket or franchise insurance coverage;

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

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

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

— Group or individual automobile insurance coverage; and

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

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

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

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

- **Effect On Benefits**

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

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

  When the Plan is secondary, the Benefits the Plan pays for Covered Services may be reduced because of benefits received from the Other Contracts.

  If you are eligible for Medicare Part B, the Benefits of this Plan may be reduced taking into consideration the amount that would be payable for an allowable expense under Medicare Part B whether or not you have enrolled in Part B and/or received payment from Medicare.

- **Order Of Benefit Determination**

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

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

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

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

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

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

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

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

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

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

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

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

- **Facility Of Payment**

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

- **Right of Recovery**

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

PLAN'S RIGHT OF RECOUPMENT

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

- **Plan's Right of Recoupment for Overpayment**

If the Plan pays benefits for Covered Services incurred by you or your Dependents and it is found that the payment was more than it should have been, or was made in error ("Overpayment"), the Plan has the right to obtain a refund of the Overpayment from: (i) the person to, or for whom, such benefits were paid, or (ii) any insurance company or plan, or (iii) any other persons, entities or organizations, including, but limited to Participating Providers or Out-of-Network Providers.

If no refund is received, the Plan has the right to deduct any refund for any Overpayment due up to an amount equal to the Overpayment, from:

— any future Benefit payment made to any person or entity under this benefit booklet, wether for the same or different Covered Person; or

— any future benefit payment made to any person or entity under another self-funded benefit program administered by the Plan; or

— any future benefit payment made to any person or entity under another group benefit plan or individual policy insured by the Plan; or

— any future benefit payment, or other payment, made to any person or entity; or

— any future payment owed to one or more Participating Providers or Out-of-Network Providers.

- Plan's Right of Recoupment for Third Party Proceeds

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

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

PLAN'S RIGHT OF SUBROGATION

The Plan shall be entitled to subrogation and/or reimbursement of all rights of recovery of a covered person, his or her parent(s) and dependent(s) or a representative, guardian or trustee of the covered person, parent(s), or dependent(s) (hereinafter collectively referred as "Claimant"). The Plan is subrogated to any and all rights of recovery and causes of action that the Claimant may have against any third party that may be liable for Claimant's injury or illness for which payments have been made or are to be made by the Plan for any treatment, service, benefit, or disability because of such injury or illness. The Plan is entitled, to the extent of payments made or to be made on account of such injury or illness, to the proceeds of any settlement, judgment or payment from any source liable for making a payment relating to Claimant's injury, illness or condition. Such sources include, but are not limited to, a responsible party and/or responsible party's insurer (or self-funded protection), no fault protection, personal injury protection, medical payments coverage, financial responsibility, uninsured or underinsured insurance coverage, an employer under the provisions of a workers' compensation law and an individual policy of insurance maintained by a Claimant. The Plan's subrogation and reimbursement rights shall apply on a priority first-dollar basis to any recovery whether by suit, settlement or otherwise, whether there is a partial or full recovery and regardless of whether Claimant is made whole and regardless of whether the amounts are characterized or described as medical expenses or amounts other than for medical expenses. The Plan specifically rejects and disavows any claims that may be made under any federal or state common law defense including, but not limited to, the make-whole doctrine and/or the common fund doctrine.

The Plan's subrogation and reimbursement rights apply to any recovery without regard to Claimant's legal fees and expenses. Claimant shall be solely responsible for paying all legal fees and expenses in connection with any recovery for the underlying injury, illness or condition and the Plan's recovery shall not be reduced by such legal fees or expenses, unless the Plan Trustees in their sole discretion, agrees in writing to discount the Plan's claim by an agreed upon amount of such fees or expenses.

If the Plan makes, or is obligated to make payments on behalf of Claimant, the Plan is granted an equitable lien by agreement or a constructive trust on the proceeds of any payment, settlement or judgment received by Claimant from any source, to the extent of payments made or to be made by the Plan on Claimant's behalf. The Claimant holds in trust for the Plan's benefit that portion of the total recovery from any source that is due for payments made or to be made by the Plan and Claimant shall reimburse the Plan immediately upon recovery.

The Claimant shall immediately notify the Plan if Claimant makes a demand or pursues a claim of any nature to recover damages or other relief relating to an injury or illness for which the Plan may make payments on Claimant's behalf.

The Claimant shall not impair, release, discharge or prejudice the Plan's rights to subrogation and/or reimbursement, and to assist and cooperate with the Plan. The Claimant shall do everything necessary to enable the Plan to enforce its subrogation and reimbursement and to immediately notify the Plan upon receiving a judgment, settlement offer or compromise offer and will not settle or compromise any claims without the Plan's consent. The Claimant shall complete and/or execute any documentation required by the Plan in the enforcement of its subrogation rights. The completion and/or execution of such documents shall be a condition to receiving payment for a claim, and the Plan shall have the right to suspend all benefit payments due to Claimant or a Claimant's eligible dependent, if Claimant fails to complete and/or execute such documentation, including this Agreement. The Plan Trustees have the exclusive and absolute right and authority to interpret the Plan documents and to resolve any ambiguities which may be claimed to exist. Their decision shall be final.

LIMITATIONS ON PLAN'S RIGHT OF RECOUPMENT/RECOVERY

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

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

Claims Filing Procedures

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

Participating Providers

Participating Providers, even those outside your network, have agreed to submit claims directly to the Claims Administrator for you. When you receive Covered Services from a Network Provider, simply show your Identification Card, and claims submission will be handled for you. If you must use an Out-of-Network Provider who does not file for you, you should follow the guidelines below in submitting your claims.

REMEMBER . . .

To receive the maximum Benefits under your health care coverage, you must receive treatment from Network Providers.

Hospital Claims

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

Ambulatory Surgical Facility and Other Facility Claims

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

Physician and Other Provider Claims

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

Employee-Filed Claims

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

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

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

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

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

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

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

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

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

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

Benefit Determinations for Properly Filed Claims

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

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

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

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

Direct Claims Line

The Claims Administrator has a direct line for claims and membership inquiries. You may call the number shown on your Identification Card between 8:00 a.m. and 6:00 p.m., Monday through Friday, whenever you have a question concerning a claim or your membership.

Complaint/Appeal Procedure

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

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

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

APPEAL PROCESS (LEVEL I)

If you are not satisfied with the initial attempt to resolve your problem, or if you wish to request a review of a Benefit determination or Preauthorization decision, you must request an appeal within 180 days from the date you received notice of the adverse Benefit determination or Preauthorization notice. A Provider can also appeal the adverse Benefit determination or Preauthorization decision. The Provider's appeal will be considered an appeal on your behalf.

- **How to File an Appeal Involving a Non-Urgent Request or Claim**

  In the case of an appeal involving a non-urgent request or claim, you must submit your 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 and/or your Provider should include any documentation, including medical records, that you want to become a part of the review file. The Claims Administrator may request further information if necessary.

  — In the case of an appeal involving a non-urgent Preauthorization request, the Claims Administrator will provide a written response to you no later than 30 days following the date the appeal is received.

  — In the case of an appeal involving a claim other than a Preauthorization request, the Claims Administrator will provide a written response to you no later than 60 days following the date the appeal is received.

- **How to File an Appeal of a Preauthorization Request Involving Urgent Care**

  If you and/or your Provider wish to appeal a Preauthorization Request Involving Urgent Care, you may appeal by calling the Preauthorization number shown on your Identification Card.

**The Claims Administrator has established procedures for you to designate an individual to act on your behalf with respect to a Benefit claim or an appeal of an adverse Benefit determination. 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.*

— The Claims Administrator will respond to you no later than 72 hours after the appeal is received.

— The Claims Administrator's response to a Preauthorization Request involving Urgent Care, including an adverse determination, if applicable, may be issued orally. A written notice will also be provided within three days following the oral notification.

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 Claims Administrator for re-review. The Claims Administrator will provide you with information about the Claims Administrator'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 Claims Administrator may request further information if necessary.

Please keep in mind that you are not obligated to pursue or exhaust a Level II review before bringing a civil action. If these review processes do not provide a satisfactory resolution to your claim for Benefits, legal remedies are available, including pursuing your claim in court.

Employee Retirement Income Security Act of 1974 (ERISA)

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

If the Health Benefit Plan is part of an "employee welfare benefits plan" and "welfare plan" as those terms are defined in ERISA:

- The Plan Administrator will furnish summary plan descriptions, annual reports, and summary annual reports to you and other plan participants and to the government as required by ERISA and its regulations.
- The Claims Administrator will furnish the Plan Administrator with this Benefit Booklet as a description of benefits available under this Health Benefit Plan. Upon written request by the Plan Administrator, the Claims Administrator will send any information which the Claims Administrator has that will aid the Plan Administrator in making its annual reports.
- Claims for benefits must be made in writing on a timely basis in accordance with the provisions of this Health Benefit Plan. Claim filing and claim review health procedures are found in the ***Claims Filing Procedures*** and ***Complaint/Appeal Procedure*** sections of this Benefit Booklet.
- Blue Cross and Blue Shield of Oklahoma, as the Claims Administrator is not the ERISA "Plan Administrator" for benefits or activities pertaining to the Health Benefit Plan.
- This Benefit Booklet is not a summary plan description.
- The Plan Administrator has given the Claims Administrator the authority and discretion to interpret the Health Benefit Plan provisions and to make eligibility and benefit determination. The Plan Administrator has full and complete authority and discretion to make decisions regarding the Health Benefit Plan's provisions and determining questions of eligibility and benefits. Any decisions made by the Plan Administrator shall be final and conclusive.

Check with your Group Administrator to see if your Group Health Plan is governed by ERISA.

Definitions

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

Actively at Work

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

Allowable Charge

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

For Comprehensive Health Care Services:

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

NOTE: For Covered Services received outside the state of Oklahoma, the "Allowable Charge" will be determined by the Blue Cross and Blue Shield Plan (Host Plan) servicing the area. Payment will be based upon the Provider payment arrangements in effect between the Provider and the on-site Plan. For information regarding Out-of-Network Provider services refer to *"Benefits for Services Outside the Sate of Oklahoma"* in the ***General Provisions*** section for additional information.

Ambulatory Surgical Facility

A Provider with an organized staff of Physicians which:

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

Benefit Period

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

Benefits

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

BlueCard Provider

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

Calendar Year

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

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.

Covered Person

The Member and each of his or her Dependents covered under this Plan.

Covered Service

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

Creditable Coverage

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

Custodial Care

Aid to patients who need help with daily tasks like bathing, eating, dressing and walking. Custodial Care does not directly treat an injury or illness and does not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed..

Deductible

A specified amount of Covered Services that you must incur during each Benefit Period before the Plan will start to pay its share of the remaining Covered Services. Refer to the ***Schedule of Benefits*** for any Deductibles applicable to your coverage.

Dependent

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

Diagnostic Service

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

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

Durable Medical Equipment

Equipment which meets the following criteria:

- It is used in the Covered Person's home, place of residence or dwelling;
- It provides therapeutic benefits or enables the Covered Person to perform certain tasks that he or she would be unable to perform otherwise due to certain medical conditions and/or illnesses;
- It can withstand repeated use and is primarily and customarily used to serve a medical purpose;

- It is generally not useful to a person in the absence of an illness or injury and is appropriate for use in the home; and
- It is prescribed by a Physician and meets the Claims Administrator's criteria of Medical Necessity for the given diagnosis.

EFFECTIVE DATE

The date when your coverage begins.

ELIGIBLE PERSON

A person entitled to apply to be an Member as specified in the ***Eligibility, Enrollment, Changes & 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.

EMPLOYER

Sheet Metal Workers' Local 270 Welfare Fund

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 Claims Administrator determines** that:

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

GROUP

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

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.

Home Health Care Agency

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

Hospice

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

Hospital

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

- Is licensed;
- Mainly provides Inpatient diagnostic and therapeutic services under the supervision of Physicians;
- Has organized departments of medicine and major Surgery;
- Provides 24-hour nursing service; and
- Is not, other than incidentally, a:
  - Skilled Nursing Facility;
  - Nursing home;
  - Custodial Care home;
  - Health resort;
  - Spa or sanitarium;
  - Place for rest;
  - Place for the aged;
  - Place for the treatment of Mental Illness;
  - Place for the treatment of 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 Claims Administrator, bearing the Member's name, identification number and the Plan.

Initial Enrollment Period

The 31-day period immediately following the date an Member or Dependent first becomes eligible to Enroll for coverage under the Plan.

Inpatient

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

Intensive Outpatient Treatment

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

Licensed Practical or Vocational Nurse (LPN or LVN)

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

Maintenance Prescription Drug

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

Maternity Services

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

Medical Care

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

Medically Necessary (or Medical Necessity)

Health care services that the Plan determines a Hospital, Physician or other Provider exercising prudent clinical judgement, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

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

Medicare

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

Member

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

Member and Children Coverage

Coverage under the Plan for the Member and his or her Dependent child(ren).

Member Only Coverage (or Single Coverage)

Coverage under the Plan for the Member only.

Member, Spouse and Children Coverage (or Family Coverage)

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

Member and Spouse Only Coverage

Coverage under the Plan for the Member and his or her spouse only.

Mental Illness

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

Network Provider

A Provider who has entered into a Participating Provider Agreement with the Claims Administrator to bill directly for the Covered Services and to accept the Claims Administrator's Allowable Charge as payment for such Covered Services. Network Provider Services include BlueCard Providers outside the state of Oklahoma.

Open Enrollment Period

A period of 31 days immediately before the Plan's Anniversary Date (renewal date) during which an individual who previously declined coverage may Enroll for coverage under the Plan as a Late Enrollee.

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 Claims Administrator to be a Network Provider or a BlueCard Provider.

Out-of-Pocket Limit

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

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

Outpatient

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

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

Sheet Metal Workers' Local 270 Welfare Fund

Plan Administrator

Sheet Metal Workers' Local 270 Welfare Fund

Preauthorization

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

Preauthorization does not guarantee that the care and services a Covered Person receives are eligible for Benefits under the Plan. At the time the Covered Person's claims are submitted, they will be reviewed in accordance with the terms of the Plan.

Properly Filed Claim

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

Provider

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

Psychiatric Hospital

A Provider that is a state licensed Hospital that primarily specializes in the treatment of severe Mental Illnesses and/or substance abuse disorders.

Qualifying Event

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

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

Registered Nurse (RN)

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

Residential Treatment Center

A state licensed and/or state certified facility that provides a 24-hour level of residential care to patients with long-term or severe mental illnesses and/or substance abuse disorders. The care is medically monitored, with 24-hour Physician availability and 24-hour onsite nursing services. It does not include half-way houses, supervised living, group homes, boarding houses or other facilities that provide primarily a supportive environment and address long-term social needs.

Routine Nursery Care

Ordinary Hospital nursery care of the newborn Covered Person.

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 Open Enrollment Period.

SPECIALIST

A Physician who provides medical services in any generally accepted medical specialty or sub-specialty, or a Physician licensed in any duly recognized special healing arts discipline who provides health care and services generally accepted within the scope of the Physician's license.

SURGERY

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

TEMPOROMANDIBULAR JOINT DYSFUNCTION/SYNDROME (TMJ)

The treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the Temporomandibular Joint.

THERAPY SERVICE

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

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

Notices

Notice

This Group Health Plan believes this plan is a "grandfathered health plan" under the Affordable Care Act. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to your Employer or the Plan Administrator.

If your Group Health Plan is subject to the Employee Retirement Income Security Act (ERISA), you may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This Web site has a table summarizing which protections do and do not apply to grandfathered health plans. For nonfederal governmental plans, inquiries may be directed to the U.S. Department of Health and Human Services at www.healthreform.gov.

Information Provided By Your Employer

Services Not Administered By HCSC

VISION BENEFITS

VISION BENEFITS

Individuals eligible for benefits under the Welfare plan, except as otherwise provide below, are entitled to a vision benefit not to exceed Three Hundred Dollars ($300.00) per covered person, per calendar year. The benefit limited of Three Hundred Dollars ($300.00) does not apply to vision services provided to or aids purchased for an eligible individual prior to age 19. Retirees and their spouses after both have reached age 65, and persons who do not meet Eligibility Requirements as defined under the Welfare Plan are not eligible for this benefit.

This benefit is for visual needs, including eye examinations, and for vision aids, including single vision lenses, bi focal lenses, tri focal lenses, frames, and contact lenses. Invoices for any combination of these benefits may be submitted for approval up to the maximum benefit. Benefits are only available for the calendar year in which the expense for the vision services or aid was incurred. (For example if invoices totaling $400.00 were incurred in Year 1, the maximum reimbursement for such services would be $300.00. Reimbursement for the additional $100.00 would not be available in Year 2.)

Vision services may be provided an Optometrist, Opthalmologist or Optician who holds license duly issued by the State in which the person is authorized to practice and provide services within the scope of such license.

No reimbursement shall be made for the following:

- Orthotics or Vision Training and associated supplemental testing Plano Lenses (Non-Prescription)
- Cosmetic materials or procedures
- Medical or Surgical Treatment of the eyes
- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment.

To file a claim, a Vision Benefit Claim Form must be completed and submitted, along with a copy of the invoices for the vision services or aid and proof of payment of the invoices. Except for claims filed for eligible individuals under age 19, only one (1) claim per eligible individual may be filed in any one calendar year. Payment of the claim by the Fund will be no sooner than ten (10) calendar days following the receipt of the completed claim form, invoices and proof of payment by the Funds Office. FILING A CLAIM FORM WITH ONLY A CREDIT CARD RECEIPT WITHOUT A COPY OF THE INVOICE FOR THE SERVICE OR AID WILL RESULT IN DENIAL OF THE CLAIM.

EMPLOYEE ASSISTANCE PROGRAM

The Sheet Metal Workers' Local 270 Welfare Fund Employee Assistance Program (EAP) provides a highly confidential and experienced source of help for employees who are experiencing personal problems. In most instance, problems of a personal nature can be resolved without the services of the EAP. Sometimes, however, seeking outside assistance through the EAP may be in the best interest of the employee, the employee's family the Union and the Contractors.

The Plan currently retains the services of Community Care to provide the Employee Assistance Program to their members. If you think you need help, information or want to talk to a counselor, contact Community Care at one of the following numbers or use their Website:

In Tulsa: 918-594-5232

Outside Tulsa 1-800-221-3976 (Toll Free)

Website www.ccok.com (Click on EAP icon)

One of the most important reasons for selecting an outside firm is to ensure complete confidentiality. If you initiate a call to the EAP, under no circumstances will your name or situation be passed on to your supervisor or anyone else. Likewise, you will not be notified if a member of your family initiates a call to the EAP.

Who is Eligible

Journeymen/apprentice Employees and Helpers who satisfy all eligible requirements will be eligible to participate in the Employee Assistance Program when they are eligible for coverage under the Comprehensive Medical Plan. The program is also available to members of your family, including your spouse and dependents. Coverage is deliberately kept broad so that you are all those close to you can get the help you need.

Cost of the Program

There is no cost to you or a member of your family to use the EAP counselor's services. There is no charge for EAP assessment interview. At this first interview you will describe your problem(s) in detail to a trained EAP specialist. This interview will be conducted either in person or over the telephone. If additional services are needed, you will be referred to an appropriate provider. Community based resources may also be available. EAP assessments are not limited. You may seek assistance whenever necessary. Your medical benefits may help you pay the cost of health care professionals, such as doctors, psychiatrists and psychologists. All in-patient psychiatric treatment must be approved by the BlueCross BlueShield utilization review board before benefits can be payable. Please refer to the BCBS summary Plan Description for details. If the specialist refers you to non-health professional (legal, family counseling, etc.) it will be up to you to pay those costs. The EAP specialist will attempt to let you know beforehand the possible range of charges for the appropriate treatment. In guiding you to help, the Employee Assistance Program will keep in mind your ability to pay. And you should keep in mind that getting effective help is always a good investment, whatever the cost.

Which Problems Are Handled

A broad range of problems or concerns can be handled through the Employee Assistance program, including stress, anxiety, depression, marital problems, family counseling, personal financial difficulties, alcohol use, drug problems, grief and loss, sexual harassment and many other areas causing you concern. You should call the EAP even if you are not certain the Program handles your problem; chances are, the EAP may be able to help. Your Employee Assistance Program in not a cure-all, but it is a reasonable place to start dealing with problems that may be overtaking your life. For each major problem and condition, skilled, experienced professionals are available somewhere to give you help. This program is designed to put you in touch with them.

Contacting the EAP

You may call the EAP whenever you need help. EAP specialist are available 24 hours a day, seven days a week for emergencies. Simply call the local or toll-free telephone number to arrange for the free initial assessment interview. Business hours are 8a.m -5p.m on weekdays. A meeting will be arranged as soon as possible. Many problems can be resolved in discussion(s) with the EAP specialist; however, if necessary, the counselor may refer you to an appropriate professional resource.

Completely Confidentiality

One of the most important reasons for using an outside firm is to ensure absolute confidentiality. The Employer receives only a periodic statistical breakdown of Program usage. When you voluntarily contact the Employee Assistance Program, the Employer has no way of learning of your call of any details of your case. The Employee Assistance Program is entirely voluntary. No "treatment" is imposed on you. You always make the decision whether or not to see the professional help referred to you.

Prescription Drug Benefits

Ineligible Persons

Individuals who do not meet the Eligibility Requirements. Any member who are not currently enrolled in the group or has been termed.

Definitions

Coverage Year means each succeeding year beginning on the Plan date. Maximum Benefit Period is defined as each calendar year. Schedule means the attached Schedule or Benefits, which is hereby made a part of this Document, or the latest revised Schedule submitted by the Employer and accepted by the Board of Trustees of the Funds to replace the one previously effective.

Reference of schedule

When reference is made to "Benefit Provided" such term shall mean the amount of benefits specified in the Schedule of Benefits, under such heading.

Exclusions

The prescription Drug Coverage excludes the following items or prescription drugs. If not listed as an exclusion, then it is considered a covered expense. The Board of Trustees will have final authority to determine drug coverage to resolve disputes, denials and appeals.

- No OTC ACA preventive drugs will be covered
- Aspirin
- Contraceptives – following types are not covered benefit
    - Patch
    - Vaginal Contraceptives
    - Emergency Contraceptives
    - Injectable
    - Diaphragms
    - Spermicide
    - Sponges
    - Cervical Caps
    - Female Condoms
    - Progestin IUD
    - Progestin Implants
- Immunization

    - Flu vaccines
    - All other vaccines
- Allergens/Allergy Injections
- Blood and Blood Plasma
- Cosmetic Drugs (example below)
    - Renova
    - Minoxidil
    - Latisse
    - Propecia
- Fertility (examples below)
    - Profasi
    - Pregnyl
    - Follistim
    - Gonal–F
    - Bravelle
    - Menopur
- Growth Hormone – for short stature
- Immunosuppressants
- Migraine Medications
    - Injectables/Kits – Imitrex not a covered benefit (oral/nasal products are covered and on formulary)
- Miscellaneous Injectables (Non–Specialty)
    - B12
    - Testosterone
- Misellaneous Medical Supplies (DME) –Bandages, Splints
- OTC Products – all non –formulary OTC products are not a covered benefit
- Weight Loss Drugs (example below)
    - Phentermine
    - Xenical (Orlistat)
    - Belviq; Belviq XR (Lorcaserin)
    - Osymia (Phentermine – topiramate)

- Contrave (Bupropion naltrexone)
- Saxenda (Liraglutide)
- Regimex (Benzphetamine)
- Diethylpropion
- Bontril PDM (Phendimetrazine)

- Onmel
- Ziana
- Latuda brand name only
- Entresto
- Dihydroergotamine Nasal Spray
- Glumetza
- Doxycyline high cost tabs/caps
- All Multiple Sclerosis Drugs listed below are excluded from coverage with the exception of Rebif. Rebif is a formulary drug with applicable Prior Authorization requirements that need to be satisfied, prior to being dispensed.
  - Ampyra
  - Aubagio
  - Avonex
  - Betaseron
  - Copaxone
  - Extavia
  - Gilenva
  - Glatiramer
  - Glatopa
  - Lemtrada
  - Plegridy
  - Tecfidera
  - Tysabri
  - Zinbryta

PRIOR AUTHORIZATION

Prior Authorizations are required for the following medications: *Please refer to the Rx Advance formulary document for a complete listing of all drugs that require a Prior Authorization*

COPAYMENTS

Copays, the portion of the drug cost that you are responsible to pay.

- Copayments per 34 day supply at a Preferred Retail Pharmacy (WALGREENS, WALMART, PPOK/Rx Select)
    - Generic : $15.00
    - Preferred Brand: $20.00
    - Non-Preferred Brand: $20.00
- Copayments per 34 day supply at a Non-Preferred Network
    - Generic: $20.00
    - Preferred Brand: $25.00
    - Non-Preferred Brand $25.00
- Mail Order Copayments (100 day supply) and Specialty Copayments (30 day supply)
    - Generic: $15.00
    - Preferred Brand: $20.00
    - Non-Preferred Brand: $20.00
- Out-of-Network Pharmacies
    - No coverage available for Out-of-Network pharmacies

This plan includes a mandatory generic substitution program. Whenever a generic drug is available, the Prescription Drug benefit shall only pay the amount normally allowed for the generic drug. If you purchase a brand name medication that has a generic equivalent available, a penalty will be added to your applicable brand copayment. This is called a Dispense as Written (DAW) Penalty and is the difference in price between the brand name medication and its available generic.

Opioid requests for over 120MME will continue to require PA and will be reviewed for medical necessity. All Non-Formulary drugs that are not a benefit exclusion will require a Prior Authorization to be reviewed for medical necessity. Specialty drugs that cost more than $10,000 will require to be approved by the Fund prior to being covered.

You will need to obtain New 90 Day supply prescriptions from your physician. For maintenance drugs prescribed on a regular basis, you may use the mail order option. Mail Order Forms are available at the Fund Office.

SHORT TERM DISABILITY PLAN

DEFINITIONS

As used in this section:

- Employer means, The Sheet Metal Workers' Local 270 Welfare Fund.
- Employee or Member mean a person who meets all the criteria for eligibility and continued participation in the Plan, as detailed in the Eligibility Requirements.
- Plan Anniversary means June 1, 1998 and June 1 in each calendar year thereafter for as long as the Plan is in force.
- Coverage Month means each succeeding monthly period beginning on the Plan Date.
- Accidental Injury means bodily injury caused by accident occurring while this
- Plan is in force as to the Employee whose injury is the basis of claim, except as limited or excluded by the provisions of this plan.
- Sickness means sickness or disease which causes Disability commencing while this Plan is in force as to the Employee whose sickness is the basis of claim, except as limited or excluded by the provisions of this plan.
- Disability means the complete inability of the member to perform any and every duty pertaining to his occupation. For purpose of the Plan, an Employee's period of Disability begins on the first day he is under the regular care of a physician for such Disability. Further, for the purposes of this Plan, the member must be under the care of a physician other than himself or a relative and must submit certification of his continued disability.
- Commencement Date/Waiting Period means the day in a period of disability on which indemnity payments for the period of Disability begin.
- Retroactive Period shall be the period of time a Member must be disabled in order to receive any Weekly Disability Benefits.
- Maximum Benefit Period means the maximum number of weeks for which indemnity will be payable hereunder on account of any one period of Disability.
- Aggregate Limit of Liability shall be the total payable for all claims each policy year.
- Basic Weekly Earnings means the Employee's average weekly earnings, exclusive of overtime, premium bonuses, etc.
- Schedule means the attached Schedule of Benefits which is hereby made a part of this Document, or the latest of any revised Schedules submitted by the Employer and Accepted by the Board of Trustees of the Plan to replace one previously effective.
- Physician means any person who is a professional practitioner of the Healing Arts defined and recognized by law and who holds a Physician's 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.

ELIGIBILITY FOR COVERAGE; EFFECTIVE DATES

A. Any eligible member, as defined, in the Eligibility Requirements, of contributing Employers, whose employment is subject to a collective bargaining agreement between the Sheet Metal Workers International Association Local 270 and The Sheet Metal and Air Conditioning Contractors' Association of Oklahoma.

B. The amounts of indemnity provided in this Plan shall be $300.00 per week. Any increase or decrease in the amount of indemnity shall become effective on the Plan Anniversary following the date of change, provided the Employee is Actively at Work; otherwise, the change shall become effective on the date following the first day he is again Actively at Work.

BENEFITS AND PAYMENTS

A. The following provisions shall govern, where applicable, any interpretation of the following sections:

1. Reference of Schedule – When reference is made to "Weekly Indemnity", such term shall mean the amount of money specified in the Schedule under such heading. When reference is made to "Commencement Date or Waiting Period", such term shall mean the day in a period of Disability as specified in the Schedule under such heading for Accident, Sickness, or Pregnancy upon which indemnity payments for that period of Disability begin. When reference is made to be covered after the Commencement Date or Waiting Period has expired. When reference is made to "Maximum Benefit Period", such term shall mean the number of weeks specified in the Schedule under such heading for each type of Disability (Accident, Sickness or Pregnancy).

2. Benefit Calculations, Weekly Indemnity

(a) Indemnities accruing hereunder shall be paid on a weekly basis as claimed; provided the amount payable for a fractional part of a week shall be computed at the rate of one-seventh of the Weekly Indemnity for each day in such fractional party.

(b) The amount of Weekly Indemnity Payable shall not exceed $300.00 per week.

3. Successive Disabilities – Successive periods of disability separated by less than two (2) consecutive weeks of full-time, Active Work shall be considered one period of disability unless the subsequent Disability and is due to an injury or sickness entirely unrelated to the cause of the previous Disability and commences after return to full-time, Active Work. All periods of Disability related to any one Pregnancy shall be considered as one Disability.

Indemnity for Disability Due to an Accidental Injury or Sickness – Subject to all other provisions of this Plan, if Accidental Injury or Sickness results in a Disability requiring the regular care of a Physician, commencing while the Employee is covered hereunder, the Fund will pay to the Employee the applicable Weekly Indemnity for the period of such Disability (one or more full days) beginning on the applicable Commencement Date, subject to a Retroactive Period Provision, but not exceeding the Maximum Benefit s Period.

LIMITATIONS AND EXCLUSIONS

Benefits shall not be payable for:

A. Any Disability during which the Employee is not under the regular care and attendance of a physician.

B. Any Disability resulting from the Employee's participation in commission of

or attempt to commit an assault or felony;

C. Any Disability resulting from intentionally self-inflicted injury, while sane or insane,

Or Left Any Disability resulting from injury sustained while working for pay or profit, or illness for which the Member should be or is covered under Workers' Compensation, or some similar program, or while working for a non-signatory contractor.

TERMINATION OF AN EMPLOYEE'S COVERAGE

A. The coverage of any Employee shall automatically terminate immediately upon the earliest of the following dates;

1. The date of his termination of membership within the eligible classes;

2. The effective date of an amendment to this Plan which terminates coverage of any eligible class to which he belongs.

3. The date of expiration of the last period for which he has made any required contribution toward the payment of premium for his coverage hereunder.

4. The date of his entry into the military service, except for temporary duty of thirty (30) days or less

GENERAL PROVISIONS

Nonassignability – The coverage and any benefits provided hereunder are not assignable.

Notice of Claim – Written notice of claim must be given to the Plan Administrator within thirty (30) days after the occurrence of any loss covered by this plan or as soon as it is reasonably possible.

Claim Forms – The Plan Administrator, upon receipt of notice of claim, will furnish to the claimant forms for filing proof of loss.

Proof of Loss – Written proof of loss must be furnished to the Plan Administrator within ninety (90) days after the termination of the period for which it is liable.

Time of Payment of Claims – Subject to due written proof of loss, all accrued indemnities will be paid weekly, as applicable, under the Schedule and any balance remaining unpaid upon the termination of liability will be paid immediately upon receipt of due written proof claim if it was not reasonable possible to give proof, but, in no event, except in the absence of legal capacity, later than one (1) year from the time proof is otherwise required.

Payment – If any indemnity of this Plan shall be payable to the estate of the Employee, or to an Employee who is a minor otherwise not competent to give a valid release, the Plan may pay such indemnity to any person related to the Employee by blood or marriage who is deemed by the Plan to be equitably entitled hereto. Any payment made by the Plan in good faith pursuant to this provision shall fully discharge the fund to the extent of such payment.

Physical Examinations and Autopsy – The Plan, at its own expense, shall have the right and opportunity to examine the person of any Employee when and as often as it may reasonable require during the pendency of claim hereunder and to make an

Legal Actions – No action at law or in equity shall be brought to recover on the plan prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Plan. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

Disclosure Authorization – Each member, by making application for coverage hereunder, shall be deemed to have authorized any Employer, physician, nurse, relating to the diagnosis, treatment of care relating to his loss, and such authorization shall be treated as a waiver of all provisions of law forbidding them from disclosing such information and records to the Fund.

SCHEDULE OF BENEFITS

Weekly Indemnity $300.00 per week maximum

Maximum Benefit Period 26 weeks

Commencement Date Sickness, Accident and Pregnancy

Waiting Period) 14 days

*Retroactive Period Sickness, Accident and Pregnancy 14 days

*If disability continues for longer than the stated retroactive period, compensation is to be paid for 7 days of the waiting period.

EMPLOYEE LIFE INSURANCE

Fort Dearborn Life Insurance Company will pay an Employee Life Benefit if you die while insured for the Employee Life Insurance.

1. You are insured under the Policy on the date of death, and
2. Fort Dearborn Life Insurance Company received proof of death within two (2) years after the date of death.

BENEFIT:

An "Employee Life Benefit" is the benefit that will be paid if you die. The amount of the

Employee Life Benefit is $15,000 subject to any reduction of benefits as a result of age or amendment to the policy. You may specify the manner in which you desire the proceeds to be paid.

BENEFICIARY DESIGNATION:

You may designate anyone as your beneficiary and you may change your beneficiary designation at any time. Both the designation and change of your beneficiary must be done in writing.

The consent of a beneficiary is not required for you to change your beneficiary designation. Fort Dearborn Life Insurance Company will not be held liable for a payment made to another person before your written request to change your beneficiary is received at Fort Dearborn Life Insurance Company's Home Office.

MORE THAN ONE BENEFICIARY:

Benefits will be paid in equal shares to your beneficiaries unless you state otherwise in your beneficiary designation. The share of a beneficiary who does not live to receive payment will pass equally to those beneficiaries who survive unless you state otherwise in your beneficiary designation.

BENEFICIARY NOT DESIGNATED:

If you do not designate a beneficiary or if no named beneficiary lives to receive payment, then the benefit will be paid to the person or persons who appear first in the list below and who survives to receive the payment:

1. Your spouse, if living; if not,

2. In equal shares to your then living natural or adopted children, if any; if none,

3. In equals shares to your father and mother, if living; if not,

If none of these lives to receive payment, then the benefit will be paid to your estate.

WAIVER OF PREMIUM:

Your life insurance benefit may continue without the further payment of premium provided:

1. You are insured under the Policy and are Actively At Work on or after the effective date of this policy; and

2. you are under age 60; and

3. you provide Fort Dearborn Life with satisfactory written proof of Total Disability within 12 months after the date you became Total Disabled; and

4. Your Total Disability has continued without interruption for at least 9 months; and

5. you are still Totally Disabled when you submit the proof of disability; and

6. all required premium has been paid.

If waiver of premium is approved, the amount of continued insurance is subject to any reduction of benefits as a result of age or amendment to the policy.

Life insurance coverage will continue without payment of premium provided you remain Totally Disabled; and provide satisfactory written proof of continuing Total Disability upon request. You are responsible for obtaining initial and continuing proof of disability.

TERMINATION OF COVERAGE:

If you are no longer actively at work as a result of a disability, layoff, or leave of absence, you may continue to be eligible for group insurance coverage as follows;

Disability – Until the end of the eligibility period as defined in the Fund's Eligibility Requirements, provided all premiums are paid when due.

Layoff – Until the end of the month following the month during which the layoff began, provided all premiums are paid when due.

Leave of Absence- Until the end of the month following the month in which the leave of absence began, provided all premiums are paid when due; or governed by the Employer's Human Resources policy on family and medical leaves of absence, for up to 12 weeks during a leave of absence elected under the federal Family and medical Leave Act of 1993, provided the leave of absence was approved in advanced and in writing by the Employer and all premiums are paid when due.

DEFINITION OF DISABILITY:

You are diagnosed by a doctor to be completely unable to engage in any occupation for wage or profit because of Sickness or Injury.

ACCELERATED DEATH BENEFIT

The accelerated death benefit is 75% of your life insurance amount on the date proof is received you have been diagnosed with a terminal condition. For this benefit, terminal condition shall mean you have a life expectancy of 12 months or less, due to a medical condition.

REDUCTION OF BENEFIT

If your life insurance benefit is subject to an age reduction within 12 months after the date proof is received, the accelerated death benefit will be 75% of the reduced group term life insurance benefit.

BENEFIT PAYMENT

Accelerated Death Benefit will be paid during your lifetime if you or your legal representative claims the benefit and provides satisfactory proof that you have been diagnosed with a terminal condition. The benefit is payable in one lump sum to you.

LIMITATIONS

The Accelerated Death Benefit will not be payable:

1. for a terminal condition caused by a suicide attempt, while sane or insane; or self-inflicted I injuries; or

2. for a life insurance benefit that has been assigned, or

3. for a life insurance benefit payable to an irrevocable beneficiary.

CONVERSION PRIVILEGE

You may convert to an individual policy of life insurance if your life insurance ceases because:

1. Life insurance benefits under the policy cease; or

2. The Policy is amended making you ineligible for life insurance; however, in either of these situations, you must have been insured under the policy for at lease five(5) years. The amount of insurance converted in either of these situations will be the lesser of:

1. The amount of life insurance in force, less any amount for which you become eligible under this or any other group policy within 31 days after the date your life insurance ceased; or

2. $10,000.

EMPLOYEE AD&D INSURANCE

Fort Dearborn Life Insurance Company will pay an Accidental Death and Dismemberment (AD&D) Benefit for a covered loss due to an injury you sustain in an accident that occurs while you are insured for the Employee AD&D Insurance.

BENEFIT:

An "AD&D Benefit" is the benefit that will be paid for the covered losses you sustain. The AD&D Benefit for a covered loss is the benefit shown in the Table of Losses and Benefits below. Fort Dearborn Life Insurance Company will not pay more than the Full Benefit for all covered losses from one accident. The amount of the Full Benefit is shown in the Summary of Benefits.

The AD&D Benefit for loss of life will be paid to your beneficiary as stated in the beneficiary provision of the Employee Life Insurance. All other AD&D Benefits will be paid to you.

COVERED LOSS:

A "Covered Loss" is a loss that meets all of the following requirements that:

1. Is shown in the Table of Losses and Benefits below.

2. Results, directly and independently of all other causes, from an injury you sustain in an accident that occurs while you are insured for the Employee AD&D Insurance.

3. Results within 365 days from the date of the accident.

4. Is not excluded by the AD&D Exclusions.

TABLE OF LOSSES AND BENEFITS

AD&D Schedule of Loss: Benefit Amount:

- Loss of Life $15,000
- Loss of Both Hands $15,000
- Loss of Both Feet $15,000
- Loss of Sight of Both Eyes $15,000
- Loss of Speech and Hearing $15,000
- Loss of One Hand and One Foot $15,000
- Loss of One Hand and the Sight of One Eye $15,000
- Loss of One Foot and the Sight of One eye $15,000
- Loss of Sight of One Eye $7,500
- Loss of One Hand or One Foot $7,500
- Loss of Speech or Hearing $7,500
- Loss of Thumb and Index
- Finger of Same Hand $3,750

Loss of a hand or foot means the complete and permanent severance of the hand or foot at or above the wrist or ankle joint. Loss of an eye means the entire and permanent loss of the sight of that eye.

AD&D EXCLUSIONS:

No AD&D Benefit will be paid for any loss that is caused directly or indirectly, or in whole or in part, by any of the following:

1. Any disease or infirmity of mind or body, and any medical or surgical treatment thereof.

2. Any infection, except a pus-forming infection of an accidental cut or wound..

3. Suicide or attempted suicide while sane or insane.

4. Intentional self-inflicted Injury.

5. Commission of, participation in, or an attempt to commit an assault or felony...

6. War or act of war, declared or undeclared; whether or not a member of any armed forces.

7. Intoxication as defined by the laws of the jurisdiction in which the accident occurred. .

8. Travel or flight in an aircraft while a member of the crew, or while engaged in the operation of the aircraft, or giving or receiving training or instruction in such aircraft.

9. Being under the influence of any narcotic, hallucinogen, barbiturate, amphetamine, or any other controlled substance as defined in Title II of the comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless as prescribed by the your licensed physician and used in the manner prescribed. Conviction is not necessary for a determination of being under the influence.

10. Active participation in a riot. “Riot” means all forms of public violence, disorder, or disturbance of the public peace, by three or more persons assembled together, whether with or without a common intent and whether or not damage to person or property or unlawful act is the intent or the consequence of such disorder.

AGE REDUCTION SCHEDULE

Life and AD&D benefits for Classes I and III terminate at age 70. Benefits for Class II shall terminate at age 65.

Hearing Aid Benefit
Sheet Metal Workers' Local 270 Welfare Fund provides a hearing aid benefit, effective June 1, 2015, subject to the following eligibility requirements.

Beginning at age 50, Employees, including Employees under a non-bargaining unit participation agreement, eligible for coverage under the Sheet Metal Workers' Local 270 Welfare Fund may receive reimbursement for part of the cost to purchase a hearing aid. The amount of the reimbursement shall be limited to Fifty Percent (50%) of the cost of the hearing aid, and in no event shall the reimbursement exceed Three Thousand Dollars($3,000.00) Retirees, persons participating in the Fund under COBRA, and Dependents of an Employee are not eligible for this benefit. To receive the reimbursement an invoice from from the hearing aid provider along with proof of payment of the invoice must be submitted to the Fund office. Reimbursement by the Fund shall be paid no sooner than ten (10) calendar days following the thirty (30) day recession period allowed under Oklahoma law, provided that a refund of purchase price for the hearing aid has not been requested during the recession period. Employees eligible for this benefit may apply for a second reimbursement, provided the second request for reimbursement must be made during the period of eligibility in the Welfare Fund and is made at least ten (10) years after the date of the first request for the hearing aid reimbursement benefit. The documents required amount of the reimbursement and the time for reimbursement shall remain the same.

For the purpose of this hearing aid benefit, the following definitions apply:

1."Hearing aid" means any wearable instrument or devise designed or offered for the purpose of aiding or compensating for impaired human hearing and any parts, attachments, or other accessories thereto, but excluding ear molds. batteries, and cords. The term "hearing aid" does not include cochlear implants or cochlear prosthesis.

2. "Hearing aid provider" means any hearing aid dealer or fitter licensed under Oklahoma law, audiologist licensed under Oklahoma law, or any other individual who dispenses hearing aids within the state of Oklahoma.

3. "Recession period" means thirty (30) calendar days from the date the hearing aid is placed in the possession of the purchaser, during which thirty (30) calendar day period, the purchaser shall have the right to cancel the purchase for any reason if the hearing aid is returned to the hearing aid provider in the same condition as when purchased, ordinary wear and tear accepted.

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