Notice for Employees of
Oklahoma Higher Education Employee Insurance Group

EFFECTIVE JANUARY 1, 2011, IT IS AGREED that the Certificate of Benefits to which this amendment is issued for attachment is amended as set forth below:

A. AMENDMENT RESPECTING DEPENDENT ELIGIBILITY

Wherever used in the Certificate, “Dependent child” means a natural child, a stepchild, an adopted child or child Placed for Adoption (including a child for whom the Member or 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 Member or spouse is also considered a Dependent child under the Group Health Plan, provided proof of dependency is provided with the child’s application.

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

B. AMENDMENT RESPECTING PREEXISTING CONDITION PROVISIONS

The Preexisting Condition provisions of the Group Health Plan are amended so that the Preexisting Condition Exclusion shall not apply to Subscribers under age 19.

C. AMENDMENT RESPECTING LIFETIME MAXIMUMS

The Lifetime Maximum set forth in the Schedule of Benefits, or in any amendment or endorsement to the Group Contract or Certificate of Benefits, is hereby removed. Coverage under the Group Health Plan shall not be subject to any dollar Lifetime Maximum, including the separate dollar Lifetime Maximum previously for treatment of autism and autism spectrum disorders.

D. AMENDMENT RESPECTING BENEFIT PERIOD MAXIMUMS

The Benefit Period dollar maximums shown in the Schedule of Benefits, Covered Comprehensive Health Care Services section or in any amendment or endorsement issued thereto are amended as set forth below:

1. Preventive Care Services — Any Benefit Period dollar maximum specified for Preventive Care Services shall no longer apply. This includes any separate dollar maximums applicable to mammography screening, bone density testing or prostate cancer screening, are hereby removed.

2. Private Duty Nursing — Covered Services shall be limited to a maximum of 85 visits per Benefit Period. The Benefit Period dollar maximum is hereby removed.

3. Temporomandibular Joint/Syndrome Dysfunction — The Benefit Period dollar maximum is hereby removed.
4. Services Related to Treatment of Autism or Autism Spectrum Disorders — The Benefit Period dollar maximum is hereby removed. The age limit for treatment of autism or autism spectrum disorders is hereby removed. The following limitations shall apply:

- **Subscribers under age six** shall be entitled to a combined maximum of 390 visits for Physical Therapy, Occupational Therapy and Speech Therapy per Benefit Period.

- Subscribers age six and older are subject to the limitations specified under “**Outpatient Therapy Services**” as set forth in the **Comprehensive Health Care Services** section of this Certificate. No Benefits are provided for Outpatient Speech Therapy.

Other Covered Services, as specified in the Contract, Certificate or in any amendment issued thereto, related to treatment of autism or autism spectrum disorders shall not be subject to a Benefit Period maximum.

E. **AMENDMENT RESPECTING TREATMENT OF AUTISM AND AUTISM SPECTRUM DISORDERS**

Benefits for the treatment of autism and autism spectrum disorders shall no longer be limited to Subscribers under age six. However, such treatment shall be subject to the Preexisting Condition limitations of the Group Health Plan (except for Subscribers under age 19), the limitations set forth in Paragraph D, 4, above, and any other limitations set forth in the Contract/Certificate and any amendments attached thereto.

F. **AMENDMENT RESPECTING ATTENTION DEFICIT DISORDER/ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADD/ADHD)**

The Contract/Certificate is amended so that any age limitation applicable to ADD/ADHD treatment is hereby removed.

G. **AMENDMENT RESPECTING PREAUTHORIZATION/ PRECERTIFICATION**

The Contract/Certificate is amended to include the following definition:

**Preauthorization/Precertification**

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

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

- The Contract/Certificate is amended so that all references to the term “Precertification” shall have the same meaning as Preauthorization/Precertification as defined as above.

- In addition to the Precertification requirements set forth in the Group Health Plan, the following provisions shall apply:
  - **Subscriber Responsibility for Preauthorization/Precertification**
    - The Subscriber is responsible for satisfying the Contract/Certificate requirements for Preauthorization/Precertification (hereinafter “Preauthorization”). This means that the Subscriber must request Preauthorization or assure that his/her Physician, Provider of services, or a family member complies with the guidelines below. Failure to Preauthorize services may result in a reduction in Benefits as described below under “Failure to Preauthorize.”

    If the Subscriber utilizes a network Provider for Covered Services, that Provider may request Preauthorization for the services. However, it is the Subscriber’s responsibility to assure that the services are preauthorized before receiving care.
Preauthorization Process for Psychiatric Care Services

All Inpatient and Outpatient services related to treatment of Mental Illness (including Severe Mental Illness), drug addiction, substance abuse, or alcoholism must be Preauthorized by the Plan. The Subscriber or his/her Physician must call the Preauthorization number shown on the Subscriber’s Identification Card before receiving treatment. The Plan will assist in coordination of the Subscriber’s care so that his/her treatment is received in the most appropriate setting for his/her condition and that the Subscriber receives the highest level of Benefits under the Contract/Certificate. If the Subscriber does not call for Preauthorization before receiving non-emergency services, Benefits for Covered Services may be subject to a reduction in Benefits, as set forth below.

For Preauthorization requests related to Urgent Care or Emergency Care, the Subscriber should refer to the Precertification/Preauthorization procedures outlined in the Contract/Certificate.

Preauthorization Process for Services Related to Treatment of Autism or Autism Spectrum Disorders

The Preauthorization process described above shall also be applicable to the limited Benefits set forth in the section entitled, “Services Related to Treatment of Autism or Autism Spectrum Disorders.” However, covered Therapy Services (Physical, Occupational Therapy and Speech Therapy) do not require Preauthorization.

Failure to Preauthorize

If the Subscriber does not call for Preauthorization of Inpatient services, the admission will be subject to a $500 reduction in Benefits, if upon receipt of the claim, it is determined that the services were Medically Necessary. If it is determined that the services were not Medically Necessary or were Experimental/Investigational, it will be the Subscriber’s responsibility to pay the full cost of the services received.

If the Subscriber fails to obtain Preauthorization for Outpatient treatment of Mental Illness (including Severe Mental Illness), drug abuse, substance abuse, alcoholism or autism/autism spectrum disorders:

— The Plan will review the Medical Necessity of the treatment or service prior to the final benefit determination.
— If the Plan determines the treatment or service is not Medically Necessary or is Experimental/Investigational, Benefits will be reduced or denied.

AMENDMENT RESPECTING ALLOWABLE CHARGE FOR NON-CONTRACTING PROVIDERS

The Contract/Certificate is amended to reflect the following method for determining the Allowable Charge for Providers who do not have a Participating Provider agreement with Blue Cross and Blue Shield of Oklahoma (Non-Contracting Providers).

The Allowable Charge for Non-Contracting Providers for Covered Services will be the lesser of:

1. the Provider's billed charges; or
2. the Plan’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 Plan 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.
BCBSOK 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 Plan does not have any claim edits or rules, the Plan 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 Plan 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, the Member will be responsible for the difference, along with any applicable Copayment, Coinsurance and Deductible amount. This difference may be considerable. To find out an estimate of the Plan’s Non-Contracting Allowable Charge for a particular service, Members may call the customer service number shown on the back of the Blue Cross and Blue Shield of Oklahoma Identification Card.

I. AMENDMENT RESPECTING SERVICES RECEIVED OUTSIDE THE STATE OF OKLAHOMA

The Contract/Certificate is amended to reflect the following provisions related to the processing of “Out-of-Network” or “Non-Participating” Provider claims:

Blue Cross and Blue Shield Plans in other states are now required to determine the “Allowable Charge” for services received outside the state of Oklahoma. Because of this change, the following language is added to your Certificate:

When Covered Services are received outside the state of Oklahoma from a Provider who does not have a written agreement with Blue Cross and Blue Shield of Oklahoma or with the local Blue Cross and Blue Shield Plan, the “Allowable Charge” will be determined by the Blue Cross and Blue Shield Plan (Host Plan) servicing the area. This Allowable Charge will be the amount the Host Plan uses for their own local members that obtain services from local Non-Contracting Providers.

The provisions in sections G and H above supersede any language in the Contract or Certificate, under the definition of “Allowable Charge” or in any other section of the Contract/Certificate, outlining the manner in which claims are processed for services received from Out-of-Network/Non-Participating Providers or for services received outside the state of Oklahoma.

J. AMENDMENT RESPECTING COMPLAINT/APPEAL PROCEDURE

The “Voluntary Re-review Process (Level II) is hereby amended and restated as follows:

Voluntary Re-Review Process (Level II)

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

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

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

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

The Group Health Plan believes this coverage 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 the Contract/Certificate 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 for any individual.

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 may be directed to the Employer or Group Administrator.

If the Group Health Plan is subject to the Employee Retirement Income Security Act (ERISA), requests for additional information may be directed to the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website 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.

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

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

President of Blue Cross and Blue Shield of Oklahoma