Plan: A

Blue Cross and Blue Shield of Oklahoma

A Wholly Owned Subsidiary of Blue Cross and Blue Shield of Oklahoma, a Member of the Blue Cross and Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans.

Schedule of Benefits - Plan A

A. Physician Services

The benefits listed below will be provided to Members only when Medically Necessary Covered Services are performed, prescribed, directed or Preauthorized by the Primary Care Physician the Member has selected.

<table>
<thead>
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<th>COPAYMENT</th>
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<tr>
<td>$5 per visit*</td>
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<td>50% of allowable charge**</td>
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1. Physician services, office, Hospital or home visits
2. Specialist care and consultation
3. Diagnostic, radiology, ultrasound and laboratory procedures
4. Immunizations
5. Periodic physical examinations
6. Vision and hearing screening to age 19 (one per year)
7. Well baby care
8. Allergy testing
9. Allergy treatment and allergy serum
10. Services of a surgeon and an anesthesiologist, including surgical procedures in
    Physician offices
11. Anesthesia services associated with any Medically Necessary dental procedure when
    provided to a Member who is severely disabled or eight years of age or under; and who
    has a medical or emotional condition which requires hospitalization or general anesthesia
    for dental care
12. Injections or infusions administered in the office

B. Inpatient Hospital and Skilled Nursing Facility Services

The benefits listed below will be provided at a Participating Hospital or Participating Skilled Nursing Facility during a
confinement for which Medically Necessary room and board charges are made and which is Preauthorized by the Primary
Care Physician the Member has selected.

<table>
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<tr>
<td>$50 per day*, per admission</td>
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1. Inpatient Hospital Services including:
   a. Unlimited number of days in a semiprivate room
   b. Intensive Care/Coronary Care
   c. Use of operating room and special treatment rooms
   d. Drugs and medications
   e. General nursing and ancillary services
   f. Administration of blood, blood plasma and blood derivatives
   g. X-ray, laboratory and diagnostic services
   h. Special duty nursing when Medically Necessary and prescribed by the Member’s
      Primary Care Physician or Specialist (20 visit limit per Calendar Year)
   i. Hospitalization for a Member who is severely disabled or eight years of age or under;
      and who has a medical or emotional condition which requires hospitalization or general
      anesthesia for dental care
2. Nursery newborn services
3. Skilled Nursing Facility/Inpatient rehabilitation
   (limited to 100 days per Calendar Year, 300 day lifetime maximum)

C. Outpatient Hospital or Facility Services

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<td>NO CHARGE</td>
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1. Surgery
2. Diagnostic procedures
3. Injections or infusions
4. Radiation therapy
5. Laboratory procedures
6. Dialysis
7. Other therapies and procedures

D. Maternity Services

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<th>COPAYMENT</th>
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<td>$5 for initial visit only*</td>
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1. Physician services, including prenatal and postnatal care
2. Diagnostic, radiology, ultrasound and laboratory procedures
3. Hospital Services
E. **Outpatient Urgent Care**

1. Urgent services, supplies and medical treatment, whether in the Service Area or out of the Service Area, provided in an emergency room $75 per visit*±

2. Participating minor emergency care centers $50 per visit*

Urgent Care is defined as treatment for an unexpected illness or injury that is not an emergency, but which is severe or painful enough to require treatment within 24 hours. Examples include, but are not necessarily limited to: lacerations, high fever, vomiting and diarrhea, pulled muscles, or other similar illnesses or injuries.

If a Member needs Urgent Care, a call must be made to the Member’s BlueLincs HMO Primary Care Physician to explain the illness or injury. The Physician may instruct the Member in a method of home care, ask the Member to come to the office or advise the Member to go to a minor emergency care center or emergency room. Use of the minor emergency care center or emergency room for Urgent Care which is not Preauthorized by the Member’s Primary Care Physician is not covered. All follow-up care must be provided or prearranged through the Member’s Primary Care Physician.

F. **Outpatient Emergency Care**

1. Emergency services, supplies and medical treatment, whether in the Service Area or out of the Service Area, provided in an emergency room $75 per visit*±

2. Participating minor emergency care centers $50 per visit*

BlueLincs HMO defines Emergency Care as treatment for any 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: a) serious jeopardy to the Member’s health; b) serious impairment to bodily function; or c) serious dysfunction of any bodily organ or part. Examples include, but are not necessarily limited to: major trauma, loss of consciousness, suspected heart attacks, severe abdominal or chest pains, fractures, uncontrolled bleeding, burns, attempted suicide or poisonings.

If a Member needs Emergency Care, the Member should seek care from the nearest appropriate facility. All follow-up care required after an emergency must be provided or prearranged through the Member’s Primary Care Physician.

G. **Out of Area Benefits**

If the Member needs Urgent Care and is traveling outside the BlueLincs HMO Service Area, but within the state of Oklahoma, follow the “Urgent Care” procedures described in Section E.

If the Member needs Urgent Care and is traveling outside the state, call 1-800-810-BLUE (1-800-810-2583) or log on to www.bcbs.com to access the BlueCard® Program’s provider finder 24 hours a day.

If a Member needs Emergency Care while traveling outside the BlueLincs HMO Service Area, the Member should seek care from the nearest appropriate facility. See examples of medical emergencies under Section F. All follow-up care required after an emergency must be provided or prearranged through the Member’s Primary Care Physician.

H. **Mental Illness Services**

Benefits are provided only when Medically Necessary Covered Services are performed, prescribed, directed or Preauthorized by the Primary Care Physician the Member has selected or Preauthorized by BlueLincs.

1. Outpatient benefits include service in the office of a psychiatrist, clinical psychologist or psychiatric social worker for visits of one hour or less with a maximum of 20 visits per Calendar Year for short-term evaluation and crisis intervention including counseling for mental health problems connected with the abuse of drugs or alcohol (one intensive Outpatient session can be exchanged for first 4 visits, then for two visits of one hour or less). $20 per visit* 50% of allowable charge**

2. Inpatient benefits, including Physician services and Hospital Services, are available with a maximum of 14 Inpatient days per Calendar Year (two partial days can be exchanged for one Inpatient day). Residential care is not covered. 50% of allowable charge**

I. **Alcohol and Drug Abuse Services**

Benefits are provided only when Medically Necessary Covered Services are performed, prescribed, directed or Preauthorized by the Primary Care Physician the Member has selected.

1. Outpatient emergency detoxification for alcoholism or drug overdose when Medically Necessary $75 per visit*±

2. Inpatient detoxification 20% of allowable charge**

J. **Special Services**

1. Skilled Home Health Care Services provided by a Participating Home Health Care Agency, when recommended by the Member’s Primary Care Physician and approved in advance by the BlueLincs Medical Director, but not including meals, housekeeping and personal convenience items (coverage for physical therapy, occupational therapy and speech therapy provided at home is described in Section J.7). NO CHARGE
J. Special Services, continued
2. Voluntary family planning services when referred by the Member’s Primary Care Physician. Services must be performed by a Participating Provider. NO CHARGE
3. Services for diagnosis and treatment of infertility when referred by the Member’s Primary Care Physician. Services must be performed by a Participating Provider. 50% of allowable charge**
4. Dental services to sound natural teeth, including replacement of such teeth, required due to accidental injuries received while coverage is in force. NO CHARGE
5. DME, including casts, splints, crutches, prostheses, oxygen supplies or other appliances/supplies used exclusively for medical treatment ($1000 maximum benefit per Calendar Year) 20% of allowable charge**
6. Ambulance service for Medically Necessary emergency transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured to the closest facility that can provide Covered Services appropriate to the Member’s condition. NO CHARGE
7. Physical therapy, occupational therapy and speech therapy when prescribed by the Member’s Primary Care Physician for conditions which are judged subject to significant improvement through short-term therapy and provided in an outpatient or home setting (maximum 90 consecutive calendar days per condition). 20% of allowable charge-per visit**

K. Annual Out-of-Pocket Maximum
Annual Out-of-Pocket Maximum, per Member, per Calendar Year $1,000
This Out-of-Pocket Maximum does not include Copayments for prescription drugs, certain Inpatient mental health services, alcohol and drug abuse services, non-authorized services performed by a non-participating Provider, Self-Referral Services, supplemental services or noncovered services.
Family Coverage - After three covered family Members have reached the Out-Of-Pocket Maximum in one Calendar Year, eligible expenses for those and other covered family Members will be paid in full during the remainder of that year.

L. Exclusions and Limitations
The following services or procedures are not covered by BlueLincs HMO:
1. Services BlueLincs determines are not Medically Necessary.
2. Non-emergency services that are not authorized by the Member’s Primary Care Physician.
3. Expenses incurred while not covered by this Plan.
4. Services which BlueLincs determines are Experimental/Investigational in nature.
5. Any condition to the extent payment would have been made under Medicare if the Member had applied for Medicare and claimed Medicare benefits, or to the extent governmental units provide benefits (some state or federal laws may affect how this exclusion is applied).
6. Procedures, services and supplies related to sex transformation.
7. Physical examinations for obtaining or for continuing employment, insurance, government licensing, flight, camp, school, athletics or immunization for international travel.
8. Services (except artificial insemination) related to conception by artificial means, including in vitro fertilization and embryo transfers or reversal of voluntary, surgically-induced sterility.
9. Cosmetic surgery or complications resulting therefrom, including surgery to improve or restore personal appearance, unless: a) needed to repair conditions resulting from an accidental injury which occurs after the Member’s Effective Date; or b) for the improvement of the physiological functioning of a malformed body member (including cleft lip and cleft palate), except for services related to Orthognathic Surgery, osteotomy, or any other form of oral surgery, dentistry or dental processes to the teeth and surrounding tissue. In no event will any care and services for breast reconstruction or implantation be a Covered Service unless such care and services are performed solely and directly as a result of mastectomy or other Medically Necessary procedure.
10. Hearing aids except as provided by state law for large (51+ size) Employer groups (see Supplemental Schedule of Benefits for large groups).
11. Supportive devices for the feet, except for prosthetic appliances for prevention of complications associated with diabetes.
12. Repair and/or replacement of Durable Medical Equipment which is lost, damaged or destroyed due to improper use or abuse.
13. Refractive surgery, including lens prescriptions, corrective eyeglasses and frames or contact lenses (including the fitting of the lenses) except as may be specifically provided for in a supplemental Vision Care Schedule of Benefits. Refractive surgery is excluded.
14. Expenses for or related to transplantation of donor organs, tissues or bone marrow, except as may be specifically provided for in the Group Master Agreement. All transplants must be authorized in advance by BlueLincs.
15. Collection and storage of blood products or tissues.
16. Custodial Care, respite care, homemaker services, domiciliary or convalescent care.
17. Personal convenience or comfort items or services.
18. Care provided outside the Service Area if the need for care could have been foreseen before departing the Service Area.
19. Medical and Hospital costs resulting from a normal, full-term delivery of a baby outside of the BlueLincs Provider Network.

*+ This Copayment can only be waived if a Member is admitted to the Hospital through an emergency room visit.
* Copayments are to be collected at the time service is rendered or at the convenience of the Provider.
** Allowable charge is the billed charge less any negotiated Provider discount.
This is a Schedule of Benefits which is only intended to be an outline of available benefits. All benefits are subject to provisions of the Group Master Agreement between the Employer and BlueLincs HMO.
L. Exclusions and Limitations, continued

20. Services, supplies or charges related to Inpatient treatment for any non-covered dental procedure, except that coverage shall be provided for Hospital Services, ambulatory surgical facility services and anesthesia services associated with any Medically Necessary dental procedure when provided to a Member who is severely disabled or eight years of age or under; and who has a medical or emotional condition which requires hospitalization or general anesthesia for dental care.

21. Orthognathic Surgery, osteotomy of the mandible or maxillae, correction of malocclusion, correction of malpositions of the teeth, and items or services for care, treatment, filling, removal, replacement or artificial restoration of the alveolar processes, gums, jaws or associated structures except for: a) the treatment of accidental injury to the jaw, sound natural teeth, mouth or face occurring on or after the Member’s Effective Date; or b) for the improvement of the physiological functioning of a malformed body member, including cleft lip and cleft palate.

22. Treatment of temporomandibular joint dysfunction, including but not limited to diagnostic procedures, splints, orthodontic/orthopedic appliances, restorations necessary to increase vertical dimension or to restore or maintain functional or centric occlusion, alteration of teeth or jaws, physical therapy and medication and behavioral modification related to conditions of temporomandibular joint syndrome or any other conditions involving the jaw joint, adjacent muscles or nerves, regardless of cause or diagnosis.

23. Inpatient or Outpatient care which is necessitated in whole or in part by a non-covered condition or service.

24. Medical supplies such as dressings, antiseptic, needles, syringes (except for diabetics) and other over-the-counter items.

25. Drugs, including prescription drugs, except as may be covered by a supplemental Prescription Drug Schedule of Benefits. Inpatient drugs are covered. Insulin and diabetic supplies for diabetics are covered.

26. Surgical procedures, services or charges related to weight reduction.

27. Dietary control programs, including but not limited to the following: the dietary control program; prescription or non-prescription drugs, or medications such as vitamins (whether to be taken orally or by injection), minerals, appetite suppressants, or nutritional supplements; or any other treatment.

28. Provision of human or synthetic growth hormone or Outpatient provision of total parenteral nutrition, hyperalimentation unless authorized in advance by BlueLincs (administration and supervision are covered). Nutritional products, including supplements or replacements, for enteral or oral intake are excluded.

29. Evaluation and treatment of mental retardation (except for medical treatment) or evaluation and treatment of learning disabilities, including attention deficit disorder and behavioral and conduct disorder.

30. Psychological testing when not Medically Necessary to determine the appropriate treatment of a short-term psychiatric condition or psychological testing or therapy when it is court ordered or as a condition of parole or probation.

31. Medical Services for which the Member declines to authorize release of information to BlueLincs.

32. Work or exercise related equipment.

33. Genetic analysis, including DNA studies, chromosomal banding and gene identification studies, except when there are signs and/or symptoms of an inherited disease in the affected individual, the diagnosis would remain uncertain without such testing, the testing will impact the care and management of the affected individual and is authorized in advance by BlueLincs. BlueLincs will cover amniocentesis for use only in women age 35 or older OR for those women with a family history of inherited genetic disorders. Gene therapy is excluded.

34. Administrative fees for dialysis.

35. Physician standby services.

36. Services not specifically named in the preceding Schedule of Benefits.

37. Contraceptive devices including diaphragms and surgically implanted contraceptive devices (intrauterine devices and intradermal devices).

38. Equipment not used exclusively for medical treatment such as: air-cleaning machines or air-filtering systems recommended for allergies; bed wetting alarm monitor devices; breast pumps; earplugs; hot tubs; hand-held shower attachments. Other items may be excluded, as well.

39. Elective abortions.

40. Health care services provided by an immediate family member.

41. Refer to the Member Handbook or Group Master Agreement for the terms and conditions that apply to work related illness or injuries.
Supplemental Schedule of Benefits for Large Groups

Severe Mental Illness
Benefits for the treatment of Severe Mental Illness will be equal to the benefits provided under the Agreement for treatment of all other physical diseases and disorders, subject to the same provisions regarding Copayments*, Precertification/Preauthorization and utilization review mechanisms.

The term “Severe Mental Illness” means any of the following biologically based Mental Illnesses (for which the diagnostic criteria are prescribed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders):

- Schizophrenia
- Bipolar Disorder (manic-depressive illness)
- Major Depressive Disorder
- Panic Disorder
- Obsessive-Compulsive Disorder
- Schizoaffective Disorder

Treatment of other Mental Illnesses will continue to be subject to the provisions for Mental Illness services set forth in the Group Master Agreement.

Audiological Services and Hearing Aids
Benefits will be provided to Members, up to age 18, for audiological services and hearing aids, limited to every 48 months for each hearing-impaired ear; however, for children up to two years of age, up to four additional ear molds are available. Hearing aids must be prescribed, filled and dispensed by a licensed audiologist. Benefits are subject to the Copayment* provisions of the Group Master Agreement.

Wigs or Other Scalp Prostheses
Benefits shall include coverage for wigs or other scalp prostheses which are necessary for the comfort and dignity of the Member, and which are required due to hair loss resulting from radiation therapy or chemotherapy. Benefits are limited to $150 per Benefit Period per Member. Benefits are subject to the Copayment* provisions of the Group Master Agreement.

This is a product description which is only intended to be an outline of available benefits. All benefits are subject to provisions of the Group Master Agreement between the Employer and BlueLincs HMO.