BlueCross BlueShield of Oklahoma

BlueLincs HMO℠









Your Health Care Benefits Program

GHS Health Maintenance Organization, Inc. d/b/a BlueLincs HMO is a wholly-owned subsidiary of Health Care Service Corporation, a Mutual Legal Reserve Company. Both companies are independent licensees of the Blue Cross and Blue Shield Association

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

BlueLincs HMO^{SM} 0043
Schedule of Benefits for Comprehensive Health Care Services

This schedule shows the Deductibles, Copayments and/or Coinsurance amounts that apply to Covered Services described in the Comprehensive Health Care Services section of your Member Handbook. Deductibles, Copayments, Coinsurance amounts and Out-of-Pocket Limits may be subject to change or increase as permitted by applicable law. Please note that services must be Medically Necessary, as determined by BlueLincs, in order to be covered.

When you enroll, you will choose a Primary Care Provider (PCP) from a list of Participating Providers supplied by BlueLincs. If you fail to choose a PCP, one will be assigned by BlueLincs.

Subscribers must choose a PCP for themselves and each member of their family. The PCP will coordinate the Medical Care needs of the Member and refer him/her to affiliated Participating Specialists. When Members choose a PCP, they are also agreeing to use the Participating Specialists to which they are referred.

Benefit Period	Calendar Year
A. Annual Deductible – per Member, per Benefit Period	$500
B. Family Annual Deductible	$1,500
C. Annual Out-of-Pocket Limit – per Member, per Benefit Period	$1,250
D. Family Out-of-Pocket Limit	$3,750

E. Physician or Other Professional Provider Services The Benefits listed below will be provided to Members only when Medically Necessary Covered Services are performed, prescribed, directed or Prior Authorization has been obtained by the PCP the Member has selected (unless otherwise specified in the Member Handbook).	**Copayment and/or Coinsurance Amounts**
NOTE: Copayments are to be collected at the time service is rendered or at the convenience of the Provider. *NOTE: Allowable charge is the billed charge less any negotiated Provider discount.*	
1. PCP services (office, Hospital or home visits)	$25 Copayment per visit
2. Specialist care and consultations	$45 Copayment per visit
3. Preventive Care Services including: adult routine physicals and related tests (mammograms, pap smear, obstetrical/gynecological exam, colorectal cancer screening, prostate exams, bone density testing), health education and counseling, well-child care, immunizations, breast-feeding services, contraceptive devices/prescription medications	No Copayment
4. Maternity services	$25 Copayment for initial visit only per pregnancy
5. Diagnostic, radiology, ultrasound and laboratory procedures	No Copayment
6. Vision and hearing screening to age 19 (one per year)	No Copayment

7. Immunizations, except as provided under Preventive Care Services	20% of Allowable Charge
8. Allergy testing	No Copayment
9. Allergy treatment and allergy serum	50% of Allowable Charge
10. Services of a surgeon and an anesthesiologist, including surgical procedures in the Physician or Other Professional Provider's office	20% of Allowable Charge
11. Anesthesia services associated with any Medically Necessary dental procedure when provided to a Member who is severely disabled; or who has a medical or emotional condition which requires hospitalization or general anesthesia for dental care; or who, in the judgment of the treating practitioner, is not of sufficient emotional development to undergo a Medically Necessary dental procedure without the use of anesthesia.	20% of Allowable Charge
12. Injections or infusions administered in the office	20% of Allowable Charge
13. Outpatient Infusion Therapy performed in a Physician or Other Professional Provider's office, Infusion Suite or in the home *Copayment does not apply for non-maintenance drugs. Outpatient Infusion Therapy for non-maintenance drugs is subject to Coinsurance.	$50 Copayment per visit for maintenance drugs 20% of Allowable Charge for non-maintenance drugs
Some Outpatient Infusion Therapy services for routine maintenance drugs may be identified as capable of being safely administered outside of an Outpatient Hospital setting. A Member's out-of-pocket expenses may be lower when services are provided by a Physician or Other Professional Provider in an Infusion Suite, a home or an office, instead of a Hospital. Non-maintenance Outpatient Infusion Therapy services will be covered the same as any other illness.	
14. Telemedicine PCP Visits *Cost shares for Covered Services provided through Telemedicine Visits will be the same as if provided in-person, except where otherwise noted.	No Copayment
15. Telemedicine Specialist Visits *Cost shares for Covered Services provided through Telemedicine Visits will be the same as if provided in-person, except where otherwise noted.	$45 Copayment

F. Inpatient Hospital or Other Facility Services The Benefits listed below will be provided at a participating Hospital, Hospice, rehabilitation facility or Skilled Nursing Facility during a confinement for which Medically Necessary room and board charges are made and which Prior Authorization has been obtained by the Member's PCP.	**Copayment and/or Coinsurance Amounts**
NOTE: Copayments are to be collected at the time service is rendered or at the convenience of the Provider.	
1. Inpatient Hospital Services	$250 per day per admission for first 5 days, then 100%
2. Maternity labor and delivery Inpatient Hospital Services	$250 per day per admission for first 5 days, then 100%

3. Human Organ, Tissue and Bone Marrow Transplant Services	$250 per day per admission for first 5 days, then 100%
4. Skilled Nursing Facility (limited to 100 days per Benefit Period)	$100 per day per admission for first 5 days, then 100%
5. Inpatient Rehabilitation (limited to 100 days per Benefit Period)	$100 per day per admission for first 5 days, then 100%
6. Inpatient Hospice services	$100 per day per admission for first 5 days, then 100%

G. Outpatient Hospital, Ambulatory Surgical Facility or Other Facility Services	**Copayment and/or Coinsurance Amounts**
NOTE: Copayments are to be collected at the time service is rendered or at the convenience of the Provider. *NOTE: Allowable charge is the billed charge less any negotiated Provider discount.*	
1. Outpatient Hospital services including: a. Surgery b. Injections or infusions c. Radiation Therapy or Chemotherapy d. Dialysis e. Other therapies and procedures	20% of Allowable Charge
2. Diagnostic procedures including complex imaging services such as MRI, CAT and PET scans and laboratory procedures	20% of Allowable Charge
3. Outpatient Infusion Therapy for routine maintenance drugs when performed in an Outpatient Hospital *Copayment does not apply for non-maintenance drugs. Outpatient Infusion Therapy for non-maintenance drugs is subject to Coinsurance.	$500 Copayment per visit for maintenance drugs 20% of Allowable Charge for non-maintenance drugs
Some Outpatient Infusion Therapy services for routine maintenance drugs may be identified as capable of being safely administered outside of an Outpatient Hospital setting. A Member's out-of-pocket expenses may be lower when services are provided by a Physician or Other Professional Provider in an Infusion Suite, a home or an office, instead of a Hospital. Non-maintenance Outpatient Infusion Therapy services will be covered the same as any other illness.	

H. Outpatient Emergency Care	**Copayment and/or Coinsurance Amounts**
NOTE: Copayments are to be collected at the time service is rendered or at the convenience of the Provider.	
1. Emergency services, supplies and medical treatment, whether in the Service Area or out of the Service Area, provided in a Hospital emergency department (emergency room) or other comparable facility. *Copayments can only be waived if a Member is admitted to the Hospital through an emergency room visit.	$300 Copayment per visit
2. Participating Urgent Care centers	$50 Copayment per visit

A Member who needs Emergency Care should seek care from the nearest appropriate facility and call the Member's PCP within 48 hours after the incident. ***All follow-up care required after an emergency must be provided or prearranged through the Member's PCP.***

I. Out of Area Benefits
A Member who needs Emergency Care while traveling outside the BlueLincs HMO Service Area should seek treatment at the nearest appropriate facility and call their PCP within 48 hours after the incident. Examples of medical emergencies are provided under "*Emergency Care Services". All follow-up care required after an emergency must be provided or prearranged through the Member's PCP.*

J. Ambulance Services	20% of Allowable Charge
NOTE: Allowable charge is the billed charge less any negotiated Provider discount.	

K. Services Related to the Treatment of Autism Spectrum Disorder	**Copayment and/or Coinsurance Amounts**
NOTE: Copayments are to be collected at the time service is rendered or at the convenience of the Provider. *NOTE: Allowable charge is the billed charge less any negotiated Provider discount.*	
1. Outpatient Benefits include Physician or Other Professional Provider office visits, behavioral health counseling and treatment programs, direct or consultative services provided by a psychiatrist or psychologist, and therapeutic care services provided by licensed or certified speech therapists, occupational therapists or physical therapists.	$25 Copayment per office visit, or 20% of Allowable Charge for other Outpatient services
2. Inpatient facility services	$250 per day per admission for first 5 days, then 100%

L. Psychiatric Care Services Benefits are provided only when Medically Necessary Covered Services are performed, prescribed, directed or Prior Authorization has been obtained by the PCP the Member has selected.	**Copayment and/or Coinsurance Amounts**
NOTE: Copayments are to be collected at the time service is rendered or at the convenience of the Provider. *NOTE: Allowable charge is the billed charge less any negotiated Provider discount.*	
1. Outpatient Benefits include services in the office of a psychiatrist, clinical psychologist or psychiatric social worker for short-term Mental Health and Substance Use Disorder evaluation and crisis intervention.	$25 Copayment per visit, or 20% of Allowable Charge for other Outpatient services
2. Telemedicine Visits for Psychiatric Care Services *Cost shares for Covered Services provided through Telemedicine Visits will be the same as if provided in-person, except where otherwise noted.	No Copayment
3. Inpatient facility services	$250 per day per admission for first 5 days, then 100%

M. Special Services	**Copayment and/or Coinsurance Amounts**
NOTE: Copayments are to be collected at the time service is rendered or at the convenience of the Provider. *NOTE: Allowable charge is the billed charge less any negotiated Provider discount.*	
1. Home Health Care Services	No Copayment
2. Voluntary family planning services when referred by the Member's PCP. Services must be performed by a Participating Provider.	20% of Allowable Charge
3. In-home Hospice services	20% of Allowable Charge
4. Private duty nursing services when recommended by the Member's PCP or Specialist (20 visit limit per Benefit Period) and approved in advance by BlueLincs.	20% of Allowable Charge
5. Services for diagnosis and surgical treatment of medical condition causing infertility	50% of Allowable Charge
6. Dental services for accidental injury	20% of Allowable Charge
7. Durable Medical Equipment ***NOTE:*** *For Durable Medical Equipment and supplies obtained from an out-of-network Provider, either because your Provider deemed it necessary that you receive it within 24 hours, or because there was not a network Provider within 15 miles of your home address, the cost-sharing requirements will be the same as if they were obtained in-network.*	20% of Allowable Charge
8. Physical Therapy, Occupational Therapy and Speech Therapy (combined maximum of 60 visits per Benefit Period, except for treatment of Autism Spectrum Disorder).	20% of Allowable Charge
9. Manipulative Therapy (maximum of 60 visits per Benefit Period)	20% of Allowable Charge
10. Diabetes self-management training, including nutrition therapy for reasons other than weight reduction as a sole purpose.	20% of Allowable Charge
11. Prosthetic appliances	20% of Allowable Charge
12. Orthotic devices	20% of Allowable Charge
13. Audiological services and hearing aids limited to one hearing aid every 48 months for each hearing-impaired ear; up to four additional ear molds are available if Medically Necessary. Hearing aids must be prescribed, filled and dispensed by a licensed audiologist or other Provider acting within the scope of their license.	20% of Allowable Charge
14. Wigs or other scalp prostheses (limited to two per Benefit Period)	No Coinsurance
15. Self-Referral Services are available without the authorization of the Member's PCP for the following: • Obstetrical and gynecological services, including annual well woman examinations; • Annual well man exam to include prostate exam; • Outpatient professional behavioral health services. **Self-Referral Services must be provided by a BlueLincs Participating Provider.**	No Copayment for Preventive Care Services or $25 per visit for other office visit services

BlueLincs HMO℠ 0043
Schedule of Benefits for Outpatient Prescription Drugs and Related Services

This schedule shows any Deductible, Copayment and/or Coinsurance amounts that apply to the Covered Services described in the ***Outpatient Prescription Drugs and Related Services*** section of your Member Handbook. Deductible, Copayment and/or Coinsurance amounts and Out-of-Pocket Limits may be subject to change or increase as permitted by applicable law. **Please note that services must be Medically Necessary, as determined by BlueLincs, and must be included on the Drug List in order to be covered.**

BENEFIT PERIOD	Calendar Year
DEDUCTIBLE	None. Your Benefits for Outpatient Prescription Drugs and related services are *not* subject to the Benefit Period Deductible set forth in the ***Schedule of Benefits for Comprehensive Health Care Services***.
OUT-OF-POCKET LIMIT	Your Benefits for Outpatient Prescription Drugs and related services are subject to the Out-of-Pocket Limit set forth in the ***Schedule of Benefits for Comprehensive Health Care Services.*** When this limit has been paid, including any Deductible, Copayment and/or Coinsurance amounts, for Covered Prescription Drugs provided during a Benefit Period, the amount of the Allowable Charges covered by BlueLincs for such Member will increase to 100% during the remainder of the Benefit Period for Covered Prescription Drugs.
COPAYMENT/COINSURANCE	The Copayment and/or Coinsurance amount applicable to each Prescription Order is set forth below. Copayments and/or Coinsurance amounts are to be collected by the Participating Retail Pharmacy at the time the Prescription Order is dispensed or at the convenience of the Provider. **Benefits for Prescription Drugs are provided only when dispensed by a Participating Pharmacy, except in emergency situations as determined by BlueLincs.**

Any differences between the Allowable Charge of a brand name drug and the Allowable Charge of a Generic Drug for which you are responsible does apply to the Deductible or Out-of-Pocket Limit.

You may not be required to pay the difference in cost between the Allowable Charge of the brand name drug and the Allowable Charge of the Generic Drug if there is a medical reason (e.g., adverse event) you need to take the brand name drug and certain criteria are met. Your Provider can submit a request to waive the difference in cost between the Allowable Charge of the brand name drug and Allowable Charge of the Generic Drug. In order for this request to be reviewed, your Provider must send in a MedWatch form to the Food and Drug Administration (FDA) to let them know the issues you experienced with the generic equivalent. Your Physician or Other Professional Provider must provide a copy of this form when requesting the waiver. The FDA MedWatch form is used to document adverse events, therapeutic inequivalence/failure, product quality problems, and product use/medication error. This form is available on the FDA website. If the waiver is granted, applicable Copayment and/or Coinsurance amounts will still apply. For additional information, contact the customer service number on the back of your Identification Card or visit www.bcbsok.com.

Any amounts paid by you, or on your behalf, for a Covered Drug will be used to calculate your cost-sharing requirements.

Certain Covered Drugs may be available at no cost through a Participating Pharmacy for the following categories of medications: severe allergic reactions, hypoglycemia, opioid overdoses and nitrates. For additional information, contact the customer service number on the back of your Identification Card or visit www.bcbsok.com.

NOTE: The amount you may pay for a covered insulin drug shall not exceed $30 per 30-day supply or $90 per 90-day supply.

	Copayment/Coinsurance Amounts per Prescription Order For Which You Are Responsible		
Retail Pharmacy Program (Up to a 30-Day Supply)	**Preferred Participating Pharmacy**	**Participating Retail Pharmacy**	**Out-of-Network Retail Pharmacy**
Tier 1	No Copayment	$10 Copayment	Not Covered
Tier 2	$10 Copayment	$20 Copayment	Not Covered
Tier 3	$35 Copayment	$55 Copayment	Not Covered
Tier 4	$75 Copayment	$95 Copayment	Not Covered

		Copayment/Coinsurance Amounts per Prescription Order For Which You Are Responsible	
Extended Prescription Drug Supply Program (Up to a 90-Day Supply)	**Quantity Dispensed**	**Participating Extended Supply Pharmacy**	**Any Pharmacy other than the Participating Extended Supply Pharmacy**
Tier 1	1 to 90 days	No Copayment	Not Covered
Tier 2	1 to 30 days	$10 Copayment	Not Covered
	31 to 60 days	$20 Copayment	Not Covered
	61 to 90 days	$30 Copayment	Not Covered
Tier 3	1 to 30 days	$35 Copayment	Not Covered
	31 to 60 days	$70 Copayment	Not Covered
	61 to 90 days	$105 Copayment	Not Covered
Tier 4	1 to 30 days	$75 Copayment	Not Covered
	31 to 60 days	$150 Copayment	Not Covered
	61 to 90 days	$225 Copayment	Not Covered

		Copayment/Coinsurance Amounts per Prescription Order For Which You Are Responsible	
Mail-Order Pharmacy Program (Up to a 90-Day Supply)	**Quantity Dispensed**	**Participating Mail-Order Pharmacy**	**Any Pharmacy other than the Participating Mail-Order Pharmacy**
Tier 1	1 to 90 days	No Copayment	Not Covered
Tier 2	1 to 30 days	$10 Copayment	Not Covered
	31 to 60 days	$20 Copayment	Not Covered
	61 to 90 days	$30 Copayment	Not Covered
Tier 3	1 to 30 days	$35 Copayment	Not Covered
	31 to 60 days	$70 Copayment	Not Covered
	61 to 90 days	$105 Copayment	Not Covered
Tier 4	1 to 30 days	$75 Copayment	Not Covered
	31 to 60 days	$150 Copayment	Not Covered
	61 to 90 days	$225 Copayment	Not Covered

	Copayment/Coinsurance Amounts per Prescription Order For Which You Are Responsible	
Specialty Pharmacy Program (30-Day Supply)[1]	**Specialty Network Pharmacy**	**Any Pharmacy other than a Specialty Network Pharmacy**
Tier 5	$150 Copayment	Not Covered
Tier 6	$250 Copayment	Not Covered

Brand Name Drug Selection

If you receive a Brand Name Drug when a Generic Drug equivalent is available, you will be responsible for the difference between the Allowable Charge for the Brand Name Drug and the Allowable Charge for the Generic Drug equivalent. This amount is in addition to any Copayment and/or Coinsurance amount set forth in this ***Schedule of Benefits.***

Exceptions to this provision may be allowed for certain preventative medications (including prescription contraceptive medications) if your health care Provider submits a request to BlueLincs indicating that the Generic Drug would be medically inappropriate, along with supporting documentation. If BlueLincs grants the exception request, any difference between the Allowable Charge for the Brand Name Drug and the Generic Drug equivalent will be waived.

[1] *Coverage for Specialty Drugs are limited to a 30-day supply. However, some Specialty Drugs have FDA approved dosing regimens exceeding the 30-day supply limits and may be allowed greater than a 30-day supply, if allowed by your Plan Benefits. Cost share will be based on day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed.*

Prescription Drug List

The Drug List is available on BlueLincs's website at www.bcbsok.com. This list shows many commonly prescribed and clinically useful Generic Drugs and Brand Drugs to provide coverage for a broad range of diseases. Brand Drugs may be included when a Generic Drug is not available to treat a specific medical condition or the Brand Drug offers a significant advantage over available Generic Drugs as determined by BlueLincs. This listing is maintained by a committee, which is made up of current and previously practicing Physicians and pharmacists from across the country, some of whom are employed by or affiliated with Blue Cross and Blue Shield. You may call a Customer Service Representative to request an updated listing at the number shown on your Identification Card.

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Member Handbook

This Member Handbook is issued according to the terms of your Group Health Plan (the "Plan"). It contains the principal provisions of the Group Administration Document (the "Agreement"). BlueLincs HMO (also called BlueLincs, we, us or our) provides only the Benefits specified in the Agreement and the ***Schedule of Benefits for Comprehensive Health Care Services*** issued with this Member Handbook.

Only Members are entitled to Benefits from BlueLincs, and they may not transfer their rights to Benefits to anyone else. Benefits for Covered Services under the Plan will be provided only for services and supplies that are specified in this Member Handbook.

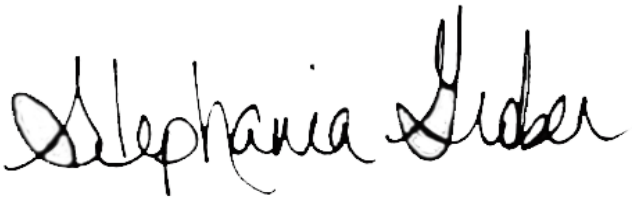
You will notice that some words or phrases start with a capital letter. Those terms may have a special meaning in the Agreement and your Member Handbook. Be sure to check the ***Definitions*** section at the end of this Handbook for an explanation of these terms. Failure to read or understand the contents of this Handbook is not a basis for appeal of any BlueLincs decision regarding the misuse of the Plan or failure to follow BlueLincs' guidelines. In the event of conflict between the Agreement and this Handbook, the terms of the Agreement shall prevail.

Your Group has contracted with BlueLincs to provide the Benefits described in this Member Handbook. BlueLincs certifies that all persons who have met the four requirements below are covered by the Agreement:

- applied for coverage under this Member Handbook;
- paid for the coverage;
- satisfied the eligibility conditions specified in the ***Eligibility, Enrollment, Changes & Termination*** section; and
- been approved by BlueLincs.

Any reference to "applicable law" will include laws and rules, including but not limited to statutes, ordinances, and administrative decisions and regulations.

Beginning on your Effective Date, we agree to provide you the Benefits described in this Member Handbook.



Chief Executive Officer

WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIMS FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.

BlueLincs Welcomes You

ABOUT BLUELINCS

BlueLincs is a wholly-owned subsidiary of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association. Health Care Service Corporation (called HCSC) conducts its insurance business through its respective state operating divisions of Blue Cross and Blue Shield of Illinois, Blue Cross and Blue Shield of Texas, Blue Cross and Blue Shield of New Mexico, Blue Cross and Blue Shield of Oklahoma and Blue Cross and Blue Shield of Montana. For purposes of this Member Handbook, the term "HCSC" includes each such operating division, as well as any additional divisions, subsidiaries or affiliates through which it may at any time conduct all or a portion of its group or consumer health insurance business. The term "affiliate" includes any entity in which HCSC has a material ownership interest or any entity that HCSC controls.

BlueLincs, as a wholly-owned subsidiary of Health Care Service Corporation, d/b/a Blue Cross and Blue Shield of Oklahoma, contracts with health care Providers who provide a comprehensive range of health care services, rather than simply reimbursing you after you have incurred medical expenses.

The key element in meeting your health care needs is to establish a strong relationship between you and your Primary Care Provider (PCP). It is important that you contact your PCP whenever you need Medical Care – including routine health care, referrals to Specialists, hospitalization and Urgent and Emergency Care. Otherwise, you may incur expenses that will not be covered by BlueLincs.

There are five documents that are necessary to understand your rights and responsibilities as a Member. Each should be carefully reviewed and retained for future use.

- **Member Handbook**

  This Member Handbook is your source of information about how your Plan works.

- **Plan Schedule of Benefits**

  The ***Schedule of Benefits*** will tell you what your Copayments, Coinsurance and/or Deductibles are for each type of service and what services are covered.

- **Supplemental Riders or Amendments, if applicable**

  Because of some state or federal laws or the special needs of your Employer, provisions called "riders" or "amendments" may be added to your Member Handbook. Be sure to check for a rider or amendment. It changes provisions or Benefits in your Member Handbook.

- **Provider Directory**

  This contains a listing of all Participating PCPs, Specialists and Hospitals.

- **Identification Card(s)**

  You will receive an Identification Card to show Providers of care when you need to use your coverage.

  Your own personal ID number is on your card. **Each of your covered Dependents will receive an Identification Card showing a separate ID number.**

  Carry your Identification Card at all times and present it to Providers of care when you need services. If you have a benefit change or change your PCP, a new Identification Card may be mailed to you.

Legal requirements govern the use of your Identification Card. You cannot let anyone else use your Identification Card. Doing so may result in immediate termination of your coverage (subject to the ***Member Complaints and Appeals*** procedures described in this Handbook).

HOW TO GET ANSWERS TO YOUR QUESTIONS

You will usually be able to answer your health care Benefit questions by referring to this Member Handbook. If you need more help, please call BlueLincs Customer Service at the number shown on your Identification Card.

How BlueLincs Works

YOUR PRIMARY CARE PROVIDER (PCP)

- **Choosing Your PCP**

  Your PCP is your personal health care manager and will share with you the responsibility for your total health care.

  The Plan requires the designation of a PCP. You have the right to designate any PCP who participates in our Network and who is available to accept you or your family members. For Dependent children, you may designate any Participating Provider who specializes in pediatric care as their PCP. If you do not designate a PCP, we will try to contact you. If we cannot reach you, BlueLincs will select a PCP for you.

  For more information about how to select a PCP and for a list of participating PCPs, visit www.bcbsok.com or contact Customer Service at the toll-free number on the back of your Identification Card.

  The BlueLincs Provider network is subject to change and the availability of any Provider cannot be guaranteed.

  You **MUST** contact your PCP whenever you need any Medical Care. When your PCP is out of the office, the doctor's staff will help you find another Physician or Other Professional Provider or you may call Customer Service. BlueLincs provides Benefits only for care received from or approved by your PCP, with the exception of Emergency Care and certain other Self-Referral Services.

- **Changing Your PCP**

  You may change your PCP up to four times per year. To change your PCP, call Customer Service at the number shown on your Identification Card. **Requests must be received no later than the 20th day of the month to be effective on the first day of the following month.** Changes are subject to PCP availability. Your new PCP is responsible for your care as of the Effective Date. You should schedule a welcome visit with your new PCP to discuss your health care needs as soon as possible.

- **OB/GYN Care**

  You are not required to obtain a referral or authorization from your PCP before obtaining Covered Services from any Participating Provider specializing in obstetrics or gynecology. However, before obtaining covered obstetrical or gynecological care, the Provider must comply with certain policies and procedures required by your Plan, including Prior Authorization and referral policies. For a list of Participating Providers who specialize in obstetrics or gynecology, visit www.bcbsok.com or contact Customer Service at the toll-free number on the back of your Identification Card.

- **Medical Group Networks**

  When you choose your PCP, you are also choosing a specific Medical Group Network. Many of BlueLincs' PCPs are with a specific Medical Group or clinic, which includes Specialists, Hospitals and other health care professionals. If your PCP is with a Medical Group or clinic, your PCP will likely coordinate referrals through his or her group of Specialists.

INDEPENDENT CONTRACTOR RELATIONSHIPS

The relationships among BlueLincs and its Participating Providers are independent contractor relationships. These individuals, institutions or agencies are not agents or employees of BlueLincs. Neither BlueLincs nor any of its employees is an employee or agent of any Participating Provider.

PCPs maintain the Provider-patient relationship with Members and are solely responsible to Members for all Covered Services that are rendered by them.

Neither you nor your Employer is an agent or representative of BlueLincs, its agents or employees, or any Participating Provider or other person or organization with which BlueLincs has made or shall make arrangements for Covered Services under the Agreement.

If you have any questions about how your Physician or other health care Providers are compensated for providing you services, BlueLincs encourages you to discuss this issue with your Physician or other Provider.

Members are subject to all rules and regulations of each Hospital and any other Provider that provides Benefits for Covered Services.

PHYSICIAN OR OTHER PROFESSIONAL PROVIDER APPOINTMENTS

You will need to make an appointment for each visit to your PCP or Specialist as approved by your PCP.

If you need to cancel an appointment, please do so 24 hours in advance. This is a courtesy to your Provider and other patients who may need that available appointment.

BlueLincs is not responsible for any Physician or Other Professional Provider charges resulting from a missed appointment when a Member fails to cancel a scheduled appointment.

COPAYMENTS, COINSURANCE AND/OR DEDUCTIBLES

You, as a Member, have a responsibility to pay any Copayment, Coinsurance and/or Deductible amounts as outlined in your ***Schedule of Benefits***.

Copayment is defined as an amount you must pay in connection with the delivery of Covered Services.

Coinsurance is defined as the *percentage* of Allowable Charges for Covered Services for which the Member is responsible.

Deductible is defined as a specified dollar amount of Covered Services that you must incur before BlueLincs will start to pay its share of the remaining Covered Services.

- Subscriber Only Coverage: When the Deductible specified in the ***Schedule of Benefits*** is reached, no additional Deductible will be required for Covered Services incurred by you during the remainder of the Benefit Period.
- Dependent Coverage: When a family enrolled with Dependent coverage reaches the family Deductible specified in the ***Schedule of Benefits***, no additional Deductible will be required for Covered Services incurred by you or your Eligible Dependents under the same Dependent coverage during the remainder of the Benefit Period.

Copayment, Coinsurance and/or Deductible amounts are applied to your health care costs as follows:

- The annual Deductible amount is applied once each Calendar Year for each Member.
- No family member will contribute more than the individual Deductible amount.
- Payments for Prescription Drugs, supplemental services and non-Covered Services do not apply toward the Deductible.

- If the Group changes carriers during a Benefit Period, BlueLincs will apply expenses the Member incurred during the Benefit Period for services covered under the prior contract to the Deductible of the Member's first Benefit Period under BlueLincs.
- If your shared payment is based on a percentage (Coinsurance), then the Deductible applies before Coinsurance. If your shared payment is a dollar amount (Copayment), then the Deductible applies after the Copayment.

If you have any questions regarding the application of Copayment, Coinsurance and/or Deductible as it relates to your Plan, please contact Customer Service at the number shown on your Identification Card.

OUT-OF-POCKET LIMIT

To make sure that your shared payment amounts do not become a burden, there is a limited amount of covered expenses you are required to pay during a Benefit Period. This is called your Out-of-Pocket Limit and the specific dollar amount will be listed in your ***Schedule of Benefits***. After you reach your Out-of-Pocket Limit for a specific Benefit Period, you will not have to pay any additional Copayment, Coinsurance or Deductible amounts for Covered Services during the remainder of that Benefit Period. If you have Family Coverage, refer to the Family Out-of-Pocket Limit amount specified in the ***Schedule of Benefits***.

The following services do not apply to the Out-of-Pocket Limit:

- Services, supplies or charges limited or excluded by this Member Handbook;
- Non-authorized services performed by non-Participating Providers;
- Certain Self-Referral and supplemental services; and
- Expenses not covered because a Benefit maximum has been reached.

DESIGNATING AN AUTHORIZED REPRESENTATIVE

BlueLincs 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 "*Prior Authorization Request Involving Urgent Care*", a health care professional with knowledge of your medical condition will be permitted to act as your authorized representative.

Utilization Management

UTILIZATION MANAGEMENT

Utilization management may be referred to as Medical Necessity reviews, utilization review (UR), or medical management reviews. A Medical Necessity review for a procedure/service, Inpatient admission, and length of stay is based on BlueLincs Medical Policy and/or level of care review criteria. Medical Necessity reviews may occur prior to services rendered, during the course of care, or after care has been completed for a Post-Service Medical Necessity Review. Some services may require a Prior Authorization before the start of services, while other services will be subject to a concurrent or Post-Service Medical Necessity Review. If requested, services normally subject to a Post-Service Medical Necessity Review may be reviewed for Medical Necessity prior to the service through a Recommended Clinical Review as defined below.

Refer to the definition of Medically Necessary under the ***Definitions*** section of this Plan for additional information regarding any limitations and/or special conditions pertaining to your Benefits.

PRIOR AUTHORIZATION

Prior Authorization establishes in advance the Medical Necessity or Experimental/Investigational nature of certain care and services covered under this Plan. It ensures that the care and services described below for which you have obtained Prior Authorization will not be denied on the basis of Medical Necessity or Experimental/Investigational.

If Prior Authorization is required, the review is not a guarantee of Benefits. Actual availability of Benefits is subject to eligibility and the other terms, conditions, limitations and exclusions of this Member Handbook.

PRIOR AUTHORIZATION RESPONSIBILITY

Your Participating Provider is responsible for obtaining Prior Authorization in those circumstances where authorization may be required and for submitting an out-of-network referral when a Member needs Medically Necessary services which are unavailable within the HMO network. Failure to follow this process for out-of-network referrals will result in denial of Benefits. The call should be made between 7:00 a.m. and 6:00 p.m., Central Time, on business days. After business hours or on weekends, call the toll-free number listed on the back of your Identification Card. Your call will be recorded and returned the next business day. A benefits management nurse will follow up with your Provider's office. All timelines for Prior Authorization requirements are provided in keeping with applicable state and federal regulations.

To determine if a specific service or category requires Prior Authorization, visit our website at www.bcbsok.com/find-care/where-you-go-matters/utilization-management for the required Prior Authorization list, which is updated when new services are added or when services are removed. You can also call BlueLincs Customer Service at the toll-free number on the back of your Identification Card.

PRIOR AUTHORIZATION REQUESTS INVOLVING NON-URGENT CARE

Except in the case of a Request Involving Urgent Care (see below), you will be provided with a written response to your request no later than 15 business days following the date we receive your request. This period may be extended one time for up to 15 additional days, if it is determined that additional time is necessary due to the nature or complexity of the request.

If an extension of time is necessary due to the need for additional information, you will be notified of the specific information needed, and you will have 45 days from receipt of the notice to provide the additional

information. If information or documents are needed from a Participating Provider, BlueLincs will request the information from the Provider. BlueLincs will provide a written response to your request for Prior Authorization within 15 days following receipt of the additional information.

The procedure for appealing an adverse Prior Authorization determination is set forth in the section entitled ***Member Complaints and Appeals***.

PRIOR AUTHORIZATION REQUESTS INVOLVING URGENT CARE

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

- could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function; or
- in the opinion of a Physician or Other Professional Provider with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Prior Authorization request.

In case of a "*Prior Authorization Request Involving Urgent Care*", BlueLincs 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).

REQUESTS INVOLVING EMERGENCY CARE

If you need Emergency Care, you should go to the nearest appropriate facility and call your PCP within 48 hours of the incident. Your PCP's telephone number can be found on your BlueLincs Identification Card. All follow-up care required after an emergency must be provided or prearranged through your PCP.

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).

Prior Authorization is not Required for Maternity Care and Treatment of Breast Cancer Unless Extension of Minimum Length of Stay Requested

Your Plan is required to provide a minimum length of stay in a Hospital facility for the following:

- Maternity Care
    - 48 hours following an uncomplicated vaginal delivery
    - 96 hours following an uncomplicated delivery by caesarean section
- Treatment of Breast Cancer
    - 48 hours following a mastectomy
    - 24 hours following a lymph node dissection

You or your Provider will not be required to obtain Prior Authorization from BlueLincs for a length of stay less than 48 hours (or 96 hours) for Maternity Care or less than 48 hours (or 24 hours) for Treatment of Breast Cancer. If you require a longer stay, you, your authorized representative, or your Provider must seek an extension for the additional days by obtaining Prior Authorization from BlueLincs.

LENGTH OF STAY/SERVICE REVIEW

Length of stay/service review is not a guarantee of Benefits. Actual availability of Benefits is subject to eligibility and the other terms, conditions, limitations and exclusions under this Plan.

Upon completion of the inpatient preadmission or emergency admission review, BlueLincs will send a letter to you, your Physician or Other Professional Provider, and/or the Hospital or facility with a determination on the approved length of service or length of stay.

An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care services are Medically Necessary. If the extension is determined not to be Medically Necessary, the coverage for the length of stay/service will not be extended, except as otherwise described in the ***Member Complaints and Appeals*** section.

A length of stay/service review, also known as a concurrent Medical Necessity review, is when you, your Provider, or other authorized representative may submit a request to BlueLincs for continued services. If you, your Provider or authorized representative requests to extend care beyond the approved time limit and it is a request involving Urgent Care or an ongoing course of treatment, BlueLincs will make a determination within 72 hours of request.

RECOMMENDED CLINICAL REVIEW

Some services that do not require Prior Authorization may be subject to review for evidence of Medical Necessity for coverage determinations that may occur prior to services rendered, during the course of care or after care has been completed for a Post-Service Medical Necessity Review.

A Recommended Clinical Review is a Medical Necessity review for a Covered Service that occurs before services are completed and helps limit the situations where you have to pay for a non-approved service. BlueLincs will review the request to determine if it meets approved BlueLincs medical policy and/or level of care review criteria for medical and behavioral health services. Once a decision has been made on the services reviewed as part of the Recommended Clinical Review process, they will not be reviewed for Medical Necessity again on a retrospective basis. Submitted services (subject to Medical Necessity review) not included as part of Recommended Clinical Review may be reviewed retrospectively.

To determine if a Recommended Clinical Review is available for a specific service, visit our website at www.bcbsok.com/find-care/where-you-go-matters/utilization-management for the Required Prior Authorization and Recommended Clinical Review list, which is updated when new services are added or when services are removed. You can also call BlueLincs Customer Service at the number on the back of your Identification Card.

Recommended Clinical Review is not a guarantee of Benefits. Actual availability of Benefits is subject to eligibility and the other terms, conditions, limitations and exclusions of this Plan. Please coordinate with your Provider to submit a request for Recommended Clinical Review.

CONTACTING BEHAVIORAL HEALTH

You, your Physician or Other Professional Provider, or your authorized representative may contact BlueLincs for a Prior Authorization or Recommended Clinical Review by calling the toll-free number shown on the back of your Identification Card and following the prompts to the Behavioral Health Unit. During regular business hours (8:00 a.m. and 6:00 p.m., Central Time, on business days), the caller will be

routed to the appropriate behavioral health clinical team for review, Outpatient requests should be requested during regular business hours. After 6:00 p.m., on weekends, and on holidays, the same behavioral health line is answered by clinicians available for Inpatient acute Recommended Clinical Reviews only. Requests for residential or partial hospitalization are reviewed during regular business hours.

General Provisions Applicable to All Recommended Clinical Reviews

1. **No Guarantee of Payment**

   A Recommended Clinical Review is not a guarantee of Benefits or payment of Benefits by the Plan. Actual availability of Benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Plan. Even if the service has been approved on Recommended Clinical Review, coverage or payment can be affected for a variety of reasons. For example, the Member may have become ineligible as of the date of service or the Member's Benefits may have changed as of the date of service.

2. **Request for Additional Information**

   The Recommended Clinical Review process may require additional documentation from the Member's health care Provider or pharmacist. In addition to the written request for Recommended Clinical Review, the health care Provider or pharmacist may be required to include pertinent documentation explaining the proposed services, the functional aspects of the treatment, the projected outcome, treatment plan and any other supporting documentation, study models, prescription, itemized repair and replacement cost statements, photographs, x-rays, etc., as may be requested by the Plan to make a determination of coverage pursuant to the terms and conditions of this Plan.

POST-SERVICE MEDICAL NECESSITY REVIEW

A Post-Service Medical Necessity Review, sometimes referred to as a retrospective review, is the process of determining coverage after treatment has been provided and is based on Medical Necessity guidelines. A Post-Service Medical Necessity Review confirms your eligibility, availability of Benefits at the time of service, and reviews necessary clinical documentation to ensure the service was Medically Necessary. Providers should submit appropriate documentation at the time of a Post-Service Review request. A Post-Service Medical Necessity Review may be performed when a Prior Authorization or Recommended Clinical Review was not obtained prior to services being rendered under certain circumstances.

General Provisions Applicable to All Post-Service Medical Necessity Reviews

1. **No Guarantee of Payment**

   A Post-Service Medical Necessity Review is not a guarantee of Benefits. Actual availability of Benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of this Plan. Post-Service Review does not guarantee payment of Benefits by the Plan, for instance a Member may become ineligible as of the date of service or the Member's Benefits may have changed as of the date of service.

2. **Request for Additional Information**

   The Post-Service Medical Necessity Review process may require additional documentation from the Member's health care Provider or pharmacist. In addition to the written request for Post-Service Medical Necessity Review, the health care Provider or pharmacist may be required to include pertinent documentation explaining the services rendered, the functional aspects of the treatment, the projected outcome, treatment plan and any other supporting documentation, study models, prescription, itemized repair and replacement cost statements, photographs, x-rays, etc., as may be requested by the Plan to make a determination of coverage pursuant to the terms and conditions of this Plan.

Eligibility, Enrollment, Changes & Termination

This section explains:

- **How** and **when** you become eligible for Benefits under the Plan;
- **Who** is considered an Eligible Dependent;
- **How** and **when** your coverage becomes effective;
- **How** to change types of coverage;
- **How** and **when** your coverage stops under the Agreement; and
- **What** rights you have when your coverage stops.

WHO IS AN ELIGIBLE PERSON

Unless otherwise specified in the Agreement, the Benefits described in this Member Handbook will be provided to persons who:

- Meet the definition of an Eligible Person as specified in the Agreement;
- Reside, live or work in the geographic area ("Network Service Area") designated by the Plan;
- Have applied for this coverage; and
- Have received a BlueLincs Identification Card.

The date you become eligible is the date you satisfy the eligibility provisions specified by your Group. Check with your Group Administrator for specific eligibility requirements which apply to your coverage.

You will not be discriminated against for coverage under this Group Health Plan on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation. Variations in the administration, processes or Benefits of this Member Handbook that are based on clinically indicated, reasonable medical management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.

WHO IS AN ELIGIBLE DEPENDENT

An Eligible Dependent is defined as:

- your spouse or Domestic Partner. NOTE: Domestic Partner coverage is available at your Group's discretion. Contact your Group Administrator for information on whether Domestic Partner coverage is available for your Group.
- your Dependent child. Wherever used in this Plan, "Dependent child" means your natural child, a stepchild, an eligible foster child, an adopted child, or a child Placed for Adoption (including a child for whom the Subscriber, your spouse or your Domestic Partner (provided your Group covers Domestic Partners) 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 Subscriber or his/her spouse or Domestic Partner is also considered a Dependent child under the Group Health Plan, provided proof of dependency is provided to BlueLincs, as appropriate.

A Dependent child who is medically certified as disabled and dependent upon the Subscriber or his/her spouse or Domestic Partner (provided the Group covers Domestic Partners), is eligible to continue coverage beyond the limiting age, provided the disability began before the child attained the age of 26.

BlueLincs reserves the right to request verification of a Dependent child's age, dependency, status as a disabled Dependent child upon initial enrollment and from time to time thereafter as BlueLincs may require.

If two Eligible Persons are married to each other or in a Domestic Partnership (provided the Group covers Domestic Partners), one may enroll as a Subscriber and the other as a Dependent, or both may be enrolled as Subscribers. Their child or children may be covered as Dependents under either person's coverage, but not under both.

HOW TO ENROLL

To enroll in the Plan, you must complete an application form provided by BlueLincs, including all information needed to determine eligibility.

IMPORTANT: In order to assure your application is processed and your coverage is effective at the earliest possible date, you must enroll during your first period of eligibility (designated by your Group).

INITIAL ENROLLMENT PERIOD

- **Initial Group Enrollment**

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

- **Initial Enrollment After the Agreement Effective Date**

  If you become an Eligible Person after the Agreement Effective Date and your application for coverage is received by BlueLincs within 31 days of being first eligible, the Effective Date for you and your Eligible Dependents (if applicable) will be assigned by BlueLincs, according to the provisions of the Agreement in effect for your Group.

  If your Group has a Waiting Period prior to the Effective Date of your coverage, such Waiting Period may not exceed 90 days, unless permitted by applicable law. If our records show that your Group has a Waiting Period that exceeds the time period permitted by applicable law, then we reserve the right to begin your coverage on a date that we believe is within the required period. Regardless of whether we exercise that right, your Group is responsible for your Waiting Period. If you have questions about your Waiting Period, please contact your Group Administrator.

- **Initial Enrollment of New Dependents**

  You can apply to add Dependents to your coverage if we receive your application within 31 days after days after you acquire an Eligible Dependent (see special rules below for newborn and adopted 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, the following rules apply:

    - If your coverage does not currently include Dependent children, you may add coverage for a newborn effective on the date of birth. However, your application to add coverage for the Dependent must be received by BlueLincs within 31 days of the child's birth. Member

contributions for newborn children, when required, must be made in accordance with the billing practices established for the Group.

- If your coverage already includes Dependent children, please contact Customer Service within 31 days of the child's birth. The Effective Date for the newborn will be the child's birth date.
- If you choose not to enroll your newborn child, coverage for the 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. There will be no additional coverage for the newborn child.

IMPORTANT: To expedite the handling of your newborn's claims, please make sure that BlueLincs receives your child's application or written notification (including your child's name and birth date) 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 the application is received by BlueLincs 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 placement papers must be submitted to BlueLincs with the application.

Subject to the ***Exclusions***, conditions and limitations of this Member Handbook, coverage for an adopted child will include the actual and documented medical costs associated with the birth of an adopted child who is 18 months of age or younger. You must provide copies of the medical bills and records associated with the birth of the adopted child and proof that you have paid or are responsible for payment of the medical bills associated with the birth and that the cost of the birth was not covered by another health care plan, including Medicaid.

QUALIFIED COURT ORDERS FOR MEDICAL COVERAGE FOR DEPENDENT CHILDREN

BlueLincs will honor certain qualified medical child support orders (QMCSO). To be qualified, a court of competent jurisdiction must enter an order for child support requiring coverage under the Plan on behalf of your children. An order or notice issued through a state administrative process that has the force of law may also provide for 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 BlueLincs to provide any type or form of Benefits or any option not otherwise provided by the Plan, except as otherwise required by law. You will be responsible for paying all applicable premium contributions, and any Copayment, Coinsurance and/or Deductible amounts or other cost sharing provisions that apply to you or your Dependent's coverage.

BlueLincs 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 concerning these procedures. The number can be found on the back of your Identification Card.

SPECIAL ENROLLMENT PERIODS

Special Enrollment Periods are provided during which individuals who previously declined coverage are allowed to enroll (without having to wait until the Group's next regular 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.

NOTE: The special enrollment provisions that apply to a spouse will also apply to a Domestic Partner (provided your Group covers Domestic Partners).

- **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 your Dependent must otherwise be eligible for coverage under the terms of the Agreement.
  - When the coverage was previously declined, you 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 your Dependent, 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:
    - you were required to provide such a statement when you declined enrollment; and
    - you were 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 you or your Dependent under the Agreement:
    - you 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 or your Dependent when enrollment was declined was not under a COBRA Continuation Coverage provision, either the other coverage has been terminated as a result of loss of eligibility for the coverage or Employer contribution toward the other coverage has been terminated.

    For purposes of the above provision, "exhaustion of COBRA Continuation Coverage" means that your 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 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, dissolution of a Domestic Partnership (if applicable), 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 you or your Dependent 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 request for Special Enrollment must be received by BlueLincs within 31 days following the loss of other coverage. Coverage under Special Enrollment must be effective no later than the first day of the month after BlueLincs receives your application for enrollment for yourself or on behalf of your Dependent(s).

NOTE: Be sure to include a copy of any supporting documentation (i.e., divorce or court papers) verifying the loss of coverage.

- **Special Enrollment for New Dependents**

  A Special Enrollment Period occurs if you have a new Dependent by birth, marriage, adoption or Placement for Adoption. **The application to enroll must be received by BlueLincs 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 child's application. 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 your child is born, adopted or Placed for Adoption.

  – Your spouse can be enrolled together with you when you marry or when your 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 he or she 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 the first day of the month after the date the application 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 application to add the Dependent is received by BlueLincs within 31 days after issuance of a court order requiring coverage be provided for a spouse or minor or Dependent child under your coverage. The Effective Date will be determined by BlueLincs in accordance with the provisions of the court order.

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

  A 60-day Special Enrollment Period occurs when Employees and Dependents who are eligible but not enrolled for the coverage in the Plan experience either of the following Qualifying Events:

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

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

An Employee 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 Employee 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 BlueLincs receives the special enrollment request.

OPEN ENROLLMENT PERIOD

If you do not enroll for coverage for yourself or your Eligible Dependent(s) during the Initial Enrollment Period or during a Special Enrollment Period, you may apply for coverage during the Group's Open Enrollment Period. An Open Enrollment Period will be held each year during the 31-day period

immediately preceding the Group's Agreement Anniversary Date (renewal date) or during another period as agreed to between the Group and BlueLincs.

TERMINATION OF A DEPENDENT'S COVERAGE

You can change your coverage to delete Dependents. The change will be effective at the end of the billing period during which the eligibility ceases.

WHEN ELIGIBILITY CONTINUES

- **Total Disability**

  If you, the Eligible Person, become Totally Disabled, your eligibility for this BlueLincs coverage will continue, provided the required premiums are paid, for a period which shall be the lesser of:

  – six months following the date you become disabled; or

  – the uninterrupted duration of the Total Disability.

- **Other**

  Check with the Group Administrator for eligibility provisions unique to your Group's coverage.

COBRA CONTINUATION COVERAGE

THIS PROVISION MAY NOT APPLY TO YOUR GROUP'S COVERAGE. PLEASE CHECK WITH YOUR GROUP ADMINISTRATOR TO DETERMINE IF YOUR GROUP IS SUBJECT TO COBRA REGULATIONS, IN ACCORDANCE WITH THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA).

- **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 Employer within 60 days of the occurrence of any of the following events:

  – Your divorce or legal separation;

  – Your Dependent child ceasing to be an Eligible Dependent under BlueLincs; or

  – The birth, adoption or Placement for Adoption of a child while you are covered under COBRA Continuation Coverage.

  For purposes of this Member Handbook, Domestic Partners are not qualified beneficiaries for COBRA Continuation Coverage.

- **Election of Continuation Coverage**

  You or your Eligible Dependent must elect COBRA Continuation Coverage within 60 days after the later occurrence of:

  – The date the Qualifying Event would cause you or your Eligible Dependent to lose coverage; or

  – The date your Employer notifies you, or your Eligible Dependent, of your COBRA Continuation Coverage rights.

- **COBRA Continuation Coverage Period**

  You and/or your Eligible Dependents are eligible for coverage to continue under your Group's coverage for a period not to exceed:

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

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

    ○ your death, divorce or legal separation, or entitlement to Medicare benefits; 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 non-disabled family members who are entitled to COBRA Continuation Coverage.

  To request the 11-month disability extension, you or your Dependent must give notice of the disability determination to the Employer before the end of the initial 18-month COBRA Continuation Coverage period, and no later than 60 days after the date of the Social Security Administration's determination. In addition, you or your Dependent must notify the Employer within 30 days after the Social Security Administration makes a determination that you or your Dependent is no longer disabled.

- **Multiple Qualifying Events**

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

- **Special TAA/ATAA Election Period**

  An Employee who loses his/her job due to a trade-related reason may be entitled to a second 60-day COBRA election period if the Employee did not elect COBRA Continuation Coverage when initially eligible to do so. In order to qualify for this election period, the U.S. Department of Labor (or a state labor agency) must issue a certification showing that the job loss was due to trade-related reasons and that the Employee is entitled to "trade adjustment assistance" (TAA) or "alternate trade adjustment assistance" (ATAA). The special 60-day election period begins on the first day of the month in which the Employee becomes eligible for trade adjustment assistance, as determined by the Department of Labor or state labor agency. The Employee is not eligible for the special election period if the TAA/ATAA eligibility determination is made more than six months after termination of employment.

WHEN COVERAGE UNDER THIS MEMBER HANDBOOK ENDS

When a Member is no longer an Eligible Person or Eligible Dependent, coverage stops at the end of the coverage period during which eligibility ceases, except as follows:

- A Member's COBRA Continuation Coverage, when applicable, will cease on the earliest to occur of the following dates:

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

- The first day of the month that begins more than 30 days after the date of the Social Security Administration's final determination that the Member is no longer disabled (when coverage has been extended from 18 months to 29 months due to disability);
- The date on which the Group stops providing any Group Health Plan to any Employee;
- The date on which coverage stops because of a Member's failure to pay to the Group any premiums required for the COBRA Continuation Coverage;
- The date on which the Member 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 Member (or the date the Member has satisfied the preexisting condition exclusion period under that plan); or
- The date on which the Member becomes (after the date of the election) entitled to benefits under Medicare.

- Your coverage will terminate retroactive to your Effective Date if you or the Group commits fraud or intentional misrepresentation of a material fact in applying for or obtaining coverage under the Agreement. Your coverage will end immediately if you file a fraudulent claim.
- If your premiums are not paid, your coverage will stop at the end of the coverage period for which your premiums have been paid.
- Termination of the Agreement automatically ends all of your coverage at the same time and date. It is the responsibility of your Group to tell you of such termination.
- In the case of an Employee whose coverage is terminated under a Group Health Plan that is not subject to COBRA Continuation Coverage, such Employee and his/her Dependents shall remain insured under the Plan for a period of 63 days after such termination, unless during such period the Employee and his/her Dependents shall otherwise become entitled to similar insurance from some other source.
- When a Member ceases to be an Eligible Dependent by reason of divorce, coverage for that Member will cease on the date the divorce is granted or on the date specified by the Member's spouse whichever is earlier, unless superseded by a court order.
- When a Member ceases to be an eligible Dependent by reason of death, coverage for that Member will cease on the date of death.
- When a Member ceases to be an Eligible Dependent child because he/she has reached the age limit for Dependent children (unless medically certified as Totally Disabled). Check with your Group Administrator for Dependent age limitations.
- Coverage of the Member shall terminate on the date the Member becomes covered under the Employer's alternate health plan (if applicable).
- When a Subscriber moves out of the BlueLincs Service Area and does not work within the BlueLincs Service Area, coverage for the Subscriber and his/her Dependents, if any, shall terminate under the Agreement on the date of the change in permanent residence.
- If applicable, adjustments in premium will be paid to the Group in accordance with the billing practices established for the Group.

WHEN YOU TURN AGE 65

Plan coverage is available to you and/or your spouse or Domestic Partner (provided your Group covers Domestic Partners) over age 65. However, the type of coverage you receive will depend upon whether you

continue to work and the rules in effect for your particular Group, including federal regulations which apply to working people age 65 and older.

Your coverage may include:

- a continuation of Group Benefits;
- a combination of Group Benefits and Medicare; or
- one of our Medicare Supplement Policies.

Check with your Group Administrator for details regarding the coverage options available to you and your Dependents (if any).

ADDRESS CHANGE

Please let BlueLincs know when you move or change your address. You can get a change of address form from your Employer or Group Benefits Administrator, and they will send the form to us.

If you are the Subscriber and you move out of the BlueLincs Service Area, it is important that you notify your Employer or Group Benefits Administrator as you may no longer be eligible for BlueLincs coverage. You may be eligible for your Employer's alternate health plan or you may call Customer Service for other coverage options.

BENEFITS AFTER TERMINATION OF THE AGREEMENT

- If the Agreement terminates because BlueLincs ceases to operate, or because the Group fails to pay premiums or fails to meet the enrollment requirements for minimum percentage and number of Eligible Persons), any Member who is hospitalized for a sickness or injury or who is pregnant on the effective date of termination shall continue to receive Benefits for Covered Services for such hospitalization or pregnancy, provided that:
  - The continuing care for hospitalization shall be for the condition under treatment until the earlier of:
    - the Member's discharge from the Hospital or Skilled Nursing Facility; or
    - expiration of Benefits according to the Agreement.
  - In maternity cases under care at the effective date of termination, BlueLincs may either, at its option:
    - continue obstetrical care through confinement and discharge; or
    - convert the Member from Group to individual membership.

  The above provisions shall not apply if the Member becomes covered under an alternate health plan, or any other plan offered by, through or in connection with the Employer as an option in lieu of coverage under the Agreement.

  BlueLincs shall have no liability for any Benefits for Covered Services incurred after termination of the Agreement, except as provided above.

- If your coverage ends because the Subscriber terminates employment, or because the Group itself is terminated, Benefits under this Plan will end on the effective date and time your coverage is terminated, except as provided below:
  - In the event the Group Health Plan is not subject to COBRA Continuation Coverage, a Member who was insured under this Plan for six months prior to the date coverage is terminated will be entitled to an extension of Benefits under this Plan if:
    - Covered Services are incurred due to illness or injury because of which the Member is Totally Disabled at the date and time such coverage is terminated; or
    - the Member has not completed a plan of surgical treatment (including maternity care and delivery expenses) which began prior to the date and time of such termination of coverage.
  - Coverage for the extension of Benefits shall be limited to a period which is the lesser of:
    - the duration of the uninterrupted existence of such Total Disability or completion of a plan of surgical treatment; or
    - the payment of maximum Benefits; or
    - six months following the date and time of termination of coverage.
- Your premiums must be submitted to BlueLincs during the period of the extension of Benefits and will be the same premiums which would have been charged for the coverage provided under this Plan had termination not occurred.
- BlueLincs shall have no liability for any Benefits for Covered Services incurred after the termination of this Plan, except as provided above.
- Benefits are not provided, even if Prior Authorization was received from BlueLincs, after a Member's coverage under this Plan is terminated.

Comprehensive Health Care Services

This section lists the Covered Services under your Member Handbook. **Please note that services must be determined to be Medically Necessary by BlueLincs in order to be covered under this Member Handbook.**

Coverage of items and services provided to you is subject to BlueLincs policies and guidelines, including, but not limited to, medical, medical management, utilization or clinical review, utilization management, and clinical payment and coding policies, which are updated throughout the plan year. These policies are resources utilized by BlueLincs when making coverage determinations and lay out the procedure and/or criteria to determine whether a procedure, treatment, facility, equipment, drug or device is Medically Necessary and is eligible as a Covered Service or is Experimental, Investigational and/or Unproven, cosmetic, or a convenience item. The clinical payment and coding policies are intended to ensure accurate documentation for services performed and require all Providers to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act ("HIPAA") approved code sets. Under the clinical payment and coding policies, claims are required to be coded correctly according to industry standard coding guidelines including but not limited to: Uniform Billing ("UB") Editor, American Medical Association ("AMA"), Current Procedural Terminology ("CPT®"), CPT® Assistant, Healthcare Common Procedure Coding System ("HCPCS"), ICD-10 CM and PCS, National Drug Codes ("NDC"), Diagnosis Related Group ("DRG") guidelines, Centers for Medicare and Medicaid Services ("CMS") National Correct Coding Initiative ("NCCI") Policy Manual, CCI table edits and other CMS guidelines. Coverage for Covered Services is subject to the code edit protocols for services/procedures billed and claim submissions are subject to applicable claim review which may include, but is not limited to, review of any terms of benefit coverage, Provider contract language, medical and medical management policies, utilization or clinical review or utilization management policies, reimbursement and coding policies as well as coding software logic, including but not limited to lab management or other coding logic or edits.

Any line on the claim that is not correctly coded and is not supported with accurate documentation (where applicable) may not be included in the covered charge and will not be eligible for payment by the Plan. The clinical payment and coding policies apply for purposes of coverage regardless of whether the Provider rendering the item or service or submitting the claim is participating or non-participating. The most up-to-date medical policies and clinical procedure and coding policies are available at www.bcbsok.com or by contacting a Customer Service Representative at the number shown on your Identification Card.

PREVENTIVE CARE SERVICES

Benefits will be provided for the following Covered Services, and Participating Provider services will not be subject to Copayment, Coinsurance and/or Deductible amounts or dollar maximums:

1. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF");
2. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved;
3. Evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") for infants, children and adolescents; and

4. With respect to women: such additional preventive care and screenings, not described in item 1 above, as provided for in comprehensive guidelines supported by the HRSA. Such services will include the following:

   NOTE: The services listed below may include requirements pursuant to state regulatory mandates and are to be covered at no cost to the Member.

   - Breastfeeding Support, Services and Supplies – Benefits will be provided for breast-feeding counseling and support services rendered by a Provider for pregnant and postpartum women. In addition, Benefits are provided for the rental of Hospital grade breast pumps (not to exceed the total cost) or purchase of manual or electric grade breast pumps, including breast pump supplies and breast milk storage supplies, with a written prescription from a Provider, and are not subject to Deductible, Copayment, Coinsurance or Benefit maximums when received from a network Provider. Benefits for electric grade breast pumps are limited to one per Benefit Period.
   - Contraceptive Services – Benefits will be provided for the following contraceptive services when prescribed by a licensed Participating Provider for women with reproductive capacity:
     - contraceptive counseling;
     - FDA-approved prescription devices and medications;
     - over-the-counter contraceptives; and
     - sterilization procedures (including, but not limited to tubal ligation), but not including hysterectomy.

     Coverage includes contraceptives in the following categories:

     - progestin-only contraceptives;
     - combination contraceptives;
     - emergency contraceptives;
     - extended-cycle/continuous oral contraceptives;
     - cervical caps;
     - diaphragms;
     - implantable contraceptives;
     - intra-uterine devices;
     - injectables;
     - transdermal contraceptives;
     - condoms; and
     - vaginal contraceptive devices.

     NOTE: Prescription contraceptive medications are covered under the ***Outpatient Prescription Drugs and Related Services*** section of this Member Handbook, *if applicable*.

     The contraceptive drugs and devices listed above may change as FDA guidelines are modified. Copayment, Coinsurance and/or Deductible amounts will not apply to FDA-approved contraceptive drugs and devices on the contraceptive Drug List. To determine if a specific drug is on the contraceptive Drug List, you may access the website at www.bcbsok.com or contact Customer Service at the toll-free number on your Identification Card.

Preventive drugs (including both prescription and over-the-counter products) that meet the preventive recommendations outlined above and that are listed on the No-Cost Preventive Drug List (to be implemented in the quantities and within the time period allowed under applicable law) will be covered and will not be subject to any Deductible, Copayment, Coinsurance or dollar maximum when obtained from a Participating Pharmacy. Drugs on the No-Cost Preventive Drug List that are obtained from a non-Participating Pharmacy, may be subject to Deductible, Copayment, Coinsurance, or dollar maximums, if applicable.

A copay waiver can be requested for drugs or immunizations that meet the preventive recommendations outlined above that are not on the No-Cost Preventive Drug List.

When obtaining the items noted above, you may be required to pay the full cost and then submit a claim form with itemized receipts to BlueLincs for reimbursement. Please refer to the ***Methods of Payment and Claim Filing*** section of your Member Handbook for claims submission information.

For the purposes of this Benefit, the current recommendations of the USPSTF regarding breast cancer screening and mammography and prevention will be considered the most current (other than those issued in or around November 2009).

Preventive Care Services will be implemented in the quantities and within the time periods allowed under applicable law. The Preventive Care Services described in items 1 through 4 above may change as USPSTF, CDC and HRSA guidelines are modified. For more information, you may access the website at www.bcbsok.com or contact Customer Service at the toll-free number listed on your Identification Card.

Examples of Covered Services included are routine annual physicals, immunizations, well-child care, cancer screening mammograms, annual routine obstetrical/gynecological examinations, bone density tests, screening for prostate cancer and colorectal cancer, tobacco use counseling and interventions (including a screening for tobacco use, counseling, and FDA-approved tobacco cessation medications), healthy diet counseling and obesity screening/counseling.

NOTE: Tobacco cessation medications are covered under the ***Outpatient Prescription Drugs and Related Services*** section of this Handbook when prescribed by a Participating Provider.

Examples of covered immunizations included are COVID-19, Diphtheria, Haemophilus influenzae type b, Hepatitis B, Measles, Mumps, Pertussis, Polio, Rubella, Tetanus, Varicella and any other immunization that is required by law for a child. Allergy injections are not considered immunizations under this Benefit provision.

Covered Services ***not*** included in items 1 through 4 above ***may*** be subject to Copayment, Coinsurance and/or Deductible amounts applicable to your coverage.

Covered Preventive Care Services received from non-Participating Providers and/or non-Participating Retail Pharmacies, or other routine Covered Services may be subject to any Copayment, Coinsurance and/or Deductible amounts applicable to your coverage.

SPECIALTY CARE

All specialty care must be coordinated in advance by your PCP, except for the following:

- services provided to a Dependent child under age 19 when rendered by a BlueLincs Participating Provider;
- obstetrical and gynecological services, including annual well woman examinations, provided such services are rendered by a BlueLincs Participating Provider;
- annual well man examinations rendered by a BlueLincs participating urologist.

If you visit a Specialist or other health care Provider without your PCP's referral for any services not listed above, you will be responsible for all charges.

The BlueLincs Provider network is subject to change, and the availability of any Provider cannot be guaranteed.

When visiting BlueLincs Participating Specialists, be sure to show your Identification Card and pay any required Copayment, Coinsurance and/or Deductible amounts.

EMERGENCY CARE SERVICES

BlueLincs defines Emergency Care Services as treatment in a Hospital emergency department (emergency room) or other comparable facility 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:

- serious jeopardy to the Member's health (or, with respect to a pregnant woman, the health of the woman or her unborn child); or
- serious impairment to bodily function; or
- serious dysfunction of any bodily organ or part; or
- with respect to a pregnant woman who is having contractions:
  - there is inadequate time to effect a safe transfer to another Hospital before delivery, or
  - transfer may pose a threat to the health or safety of the woman or the unborn child.

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.

Coverage for Emergency Care Services shall be provided in accordance with the terms and conditions of the ***Comprehensive Health Care Services*** section of this Member Handbook (for example: *"Hospital Services"* and *"Surgical/Medical Services"*). If you disagree with BlueLincs's determination in processing your Benefits as non-emergency care instead of Emergency Care, you may call Customer Service at the toll-free number on the back of your Identification Card. Please review the ***Member Complaints and Appeals*** section of this Member Handbook for specific information on your right to seek and obtain a full and fair review of your claim.

Emergency Care Services rendered by a non-Participating Provider shall be paid at the same benefit level applicable to Participating Providers. Notwithstanding anything in the Group Health Plan to the contrary, for out-of-network Emergency Care Services rendered by non-Participating 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 Participating Providers for the Emergency Care Services furnished;
2. the amount for the Emergency Care Services calculated using the same method the Group Health Plan generally uses to determine payments for out-of-network Provider services, but substituting the in-network, participating or contracting cost-sharing provisions for the out-of-network or non-Participating 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 Participating Provider Copayment or Coinsurance amounts imposed with respect to the Member.

URGENT CARE – WITHIN THE STATE OF OKLAHOMA

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. All follow-up care must be provided or prearranged through your PCP.

URGENT CARE – OUTSIDE THE STATE OF OKLAHOMA

As a BlueLincs Member, you have access to the BlueCard® Program if you become ill while traveling. The BlueCard Program allows you to receive care from outside of the geographic area in which BlueLincs' network operates. Refer to the ***Schedule of Benefits for Comprehensive Health Care Services*** (*"Outpatient Urgent Care"* and *"Out of Area Benefits")* for detailed information about this provision.

When you are away from home and you need to find information about a Provider or Hospital, you have access to our Provider Finder 24 hours a day. The Provider Finder is available by calling 1-800-810-BLUE (2583), or you may refer to the BlueCard Doctor and Hospital Finder at www.bcbsok.com. You may make an appointment with a Provider that is convenient to you.

Your care will be covered as if you had received it at home through BlueLincs. You will not have to complete a claim form or pay up front for your health services, except for those out-of-pocket expenses (non-covered services, Copayment, Coinsurance and/or Deductible amounts) that you would pay anyway.

Always remember to carry your current BlueLincs Identification Card. It contains helpful information and important phone numbers for accessing health care when you are away from home.

HOSPITAL SERVICES

Inpatient services are subject to the *"Prior Authorization"* requirements of this Member Handbook. You should verify with your PCP that Hospital Services have been approved through BlueLincs. When receiving Hospital Services, be sure to present your Identification Card and pay any required Copayment, Coinsurance and/or Deductible amounts.

- **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.

- **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 Member.
  - Routine Nursery Care does not include treatment or evaluation for medical or surgical reasons during or after the mother's maternity confinement. In the event the newborn requires such treatment or evaluation while covered under this Member Handbook:
    - the infant will be considered as a Member in its own right and will be entitled to the same Benefits as any other Member under this Member Handbook; and
    - a separate Copayment 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

We pay 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[1] 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.

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

- **Assistant Surgeon**

  Services of a Physician or Other Professional Provider 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 Plan.

- **Anesthesia**

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

- **Inpatient Medical Services**

  Medical Care when you are Inpatient for a condition not related to Surgery, pregnancy or Mental Health and Substance Use Disorder, except as specified.

  - Inpatient Medical Care Visits

    Inpatient Medical Care visits are limited to one visit or other service per day by the attending Physician.

  - Intensive Medical Care

    Constant Physician attendance and treatment when your condition requires it for a prolonged time.

  - Concurrent Care

    - Care for a medical condition by a Physician who is not your surgeon while you are in the Hospital for Surgery.
    - If the nature of the illness or injury requires, care by two or more Physicians during one Hospital stay.

  - Consultation

    Consultation by another Physician when requested by your attending Physician, **limited to one visit or other service per day for each consulting Physician**. Staff consultations required by Hospital rules are excluded.

  - Newborn Well Baby Care

    Routine Nursery Care visits to examine a newborn Member, 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 Health and Substance Use Disorder, 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.

- Standard Fertility Preservation Services

  Benefits will be provided for Standard Fertility Preservation Services for those who are within reproductive age, when Medically Necessary cancer treatments may directly or indirectly cause Iatrogenic Infertility. Standard Fertility Preservation Services are not subject to Prior Authorization requirements.

- **Biomarker Testing**

  Benefits will be provided for Medically Necessary Biomarker Testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a disease or condition.

- **Diagnostic Examination for Breast Cancer**

  Benefits will be provided for Medically Necessary and clinically appropriate examinations to evaluate abnormalities in the breast that are:

  – seen or suspected from a screening examination for breast cancer;

  – detected by another means of examination; or

  – suspected based on the medical history or family history of the individual.

  This examination may include, but is not limited to, a Diagnostic Mammogram, Breast Magnetic Resonance Imaging, or a Breast Ultrasound. Benefits for a Diagnostic Examination for Breast Cancer will be provided at no charge.

  In addition to the ***Definitions*** section of this Member Handbook, the following definitions are applicable to this provision:

  – **Diagnostic Mammogram**

    A diagnostic tool that uses x-ray and is designed to evaluate abnormality in a breast.

  – **Breast Magnetic Resonance Imaging**

    A diagnostic tool used to produce detailed pictures of the structure of the breast.

  – **Breast Ultrasound**

    A non-invasive, diagnostic imaging technique that uses high-frequency sound waves to produce detailed images of the breast.

SERVICES DELIVERED VIA TELEMEDICINE

This Plan provides Benefits for Covered Services appropriately provided through Telemedicine Visits. Benefits may be limited consistent with the coding and clinical standards recognized by the American Medical Association or the Centers for Medicare and Medicaid Services, or as otherwise allowed by applicable law. Cost-sharing amounts for Covered Services appropriately provided through Telemedicine Visits are usually the same as, and will not exceed, the cost share that would apply if those Covered Services were provided through a traditional in-person visit.

OUTPATIENT THERAPY SERVICES

- Radiation Therapy;
- Chemotherapy;
- Respiratory Therapy;
- Dialysis Treatment;

- Infusion Therapy;
- Physical Therapy, Occupational Therapy, Speech Therapy and Manipulative Therapy.

  Benefits for Outpatient Physical Therapy, Outpatient Occupational Therapy, Outpatient Speech Therapy and Outpatient Manipulative Therapy (including visits to the Member's home) are limited to the number of visits specified in the *Schedule of Benefits for Comprehensive Health Care Services* in the front of this Member Handbook. This visit limit is not applicable to Therapy Services for treatment of Autism Spectrum Disorder.

MATERNITY SERVICES

- *"Hospital Services"* and *"Surgical/Medical Services"* from a Provider to a Member or the Member's covered spouse 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 this Member Handbook after childbirth, except as otherwise provided in this section; or
  - A minimum of 96 hours of Inpatient care at a Hospital following a delivery by cesarean section for the mother and newborn infant who are covered under this Member Handbook after childbirth, except as otherwise provided in this section; and
  - Postpartum home care following a vaginal delivery if childbirth occurs at home or in a birthing center licensed as a birthing center. The coverage shall provide for one home visit within 48 hours of childbirth by a licensed health care Provider whose scope of practice includes providing postpartum care. The visits shall include, at a minimum:
    - physical assessment of the mother and newborn infant;
    - parent education regarding childhood immunizations;
    - training or assistance with breast or bottle feeding; and
    - performance of any Medically Necessary and appropriate clinical tests.

    At the mother's discretion, visits may occur at the facility of the Provider instead of the home.
- Inpatient care shall include, at a minimum:
  - physical assessment of the mother and newborn infant;
  - parent education regarding childhood immunizations;

- training or assistance with breast or bottle feeding; and
- performance of any Medically Necessary and appropriate clinical tests.

- The Plan may provide coverage for a shorter length of Hospital Inpatient stay for services related to maternity/obstetrical and newborn infant care provided:
  - The licensed health care Providers determine that the mother and newborn infant meet medical criteria contained within guidelines, developed by or in cooperation with licensed health care Providers, which recognize treatment standards, including but not limited to, the most current treatment standards of the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, that determine the appropriate length of stay based upon:
    - evaluation of the antepartum, intrapartum and postpartum course of the mother and newborn infant;
    - the gestational age, birth weight and clinical condition of the newborn infant;
    - the demonstrated ability of the mother to care for the newborn infant post discharge; and
    - the availability of post discharge follow-up to verify the condition of the newborn infant in the first 48 hours after delivery.
  - 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.

MASTECTOMY AND RECONSTRUCTIVE SURGICAL SERVICES

Subject to the ***Exclusions***, conditions and limitations of this Member Handbook (including the Copayment and/or Coinsurance provisions set forth in the ***Schedule of Benefits for Comprehensive Health Care Services***), the Benefits for the treatment of breast cancer and other breast conditions shall include the following Covered Services:

- 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 Prior Authorization and must be performed in and by a Provider that meets the criteria established by BlueLincs for assessing and selecting Providers for transplants.

Prior Authorization must be obtained at the time the Member is referred for a transplant consultation and/or evaluation. It is the Member's responsibility to make sure Prior Authorization is obtained. Failure to obtain Prior Authorization may result in denial of Benefits. BlueLincs has the sole and final authority for approving or declining requests for Prior Authorization.

- **Definitions**

  In addition to the definitions listed under the ***Definitions*** section of this Member Handbook, 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.

  - **Prior Authorization**

    The process that determines in advance the Medical Necessity or Experimental, Investigational and/or Unproven nature of certain care and services under this Handbook. Prior Authorization is

subject to all conditions, exclusions and limitations of this Handbook. Prior Authorization does not guarantee that all care and services a Member receives are eligible for Benefits under the Agreement.

- **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**

  Subject to the ***Exclusions***, conditions and limitations of this Agreement, (including the Copayment, Coinsurance and/or Deductible provisions set forth in the ***Schedule of Benefits for Comprehensive Health Care Services***), Benefits will be provided for Covered Services rendered by a Hospital, Physician, or other Provider for the human organ and tissue transplant procedures set forth below.

  - Musculoskeletal transplants;
  - Parathyroid transplants;
  - Cornea transplants;
  - Heart-valve transplants;
  - 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 BlueLincs HMO for assessing and performing organ or tissue transplants, or Bone Marrow Transplant procedures, as set forth in the BlueLincs HMO's written medical policies.
  - In addition to the Exclusions set forth elsewhere in the Agreement and this Member Handbook, 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 BlueLincs HMO's written medical policies.
- Any organ or tissue transplant or Bone Marrow Transplant procedure which BlueLincs HMO 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 Member 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 this Handbook.

– The transplant must be performed in and by a Provider that meets the criteria established by BlueLincs HMO 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 Members, each is entitled to the Benefits of this Agreement.

  – When only the recipient is a Member, both the donor and the recipient are entitled to the Benefits of this Agreement. 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 this Member Handbook.

  – When only the living donor is a Member, the donor is entitled to the Benefits of this Agreement. 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 and Blue Shield coverage or any government program available to the recipient. There are no Covered Services for the non-Member transplant recipient.

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

  – BlueLincs HMO 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 Agreement 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 Member 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 this Member Handbook.

AMBULATORY SURGICAL FACILITY SERVICES

Ambulatory Hospital-type services, not including Physician or Other Professional Provider services, given to you in and by an Ambulatory Surgical Facility only when:

- Such services are Medically Necessary;
- A Surgery which cannot be done in a Physician's office is actually performed; and
- The Surgery is a Covered Service under this Member Handbook.

SERVICES RELATED TO TREATMENT OF AUTISM SPECTRUM DISORDER

Covered Services which are Medically Necessary for the screening, diagnosis and treatment of Autism Spectrum Disorder, provided the Member continually and consistently shows sufficient progress and improvement as determined by the health care Provider.

Treatment of Autism Spectrum Disorder consists of evidence-based care and related equipment prescribed or ordered for an individual diagnosed with an Autism Spectrum Disorder by a licensed Physician or a licensed doctoral-level psychologist who determines the care to be Medically Necessary, including but not limited to:

- Behavioral health counseling and treatment programs, including Applied Behavior Analysis, that are:
  - necessary to develop, maintain or restore, to the maximum extent practicable, the functioning of an individual; and
  - provided or supervised by a board-certified behavior analyst, a board-certified assistant behavior analyst or by a licensed doctoral-level psychologist so long as the services performed are commensurate with the psychologist's university training and experience.
- Medications prescribed by a licensed Physician or Other Professional Provider and any health-related services deemed Medically Necessary to determine the need or effectiveness of the medications.
- Direct or consultative services provided by a psychiatrist or psychologist licensed in the state in which the psychiatrist or psychologist practices.
- Therapeutic care services provided by licensed or certified speech therapists, occupational therapists or physical therapists. Speech Therapy, Physical Therapy and Occupational Therapy visits related to treatment of Autism Spectrum Disorder are not subject to the limitations specified under "*Outpatient Therapy Services"*.

Except for Inpatient services, if a Member is receiving treatment for an Autism Spectrum Disorder, BlueLincs shall have the right to review the treatment plan annually, unless BlueLincs and the Member's treating Physician or psychologist agree that a more frequent review is necessary. Any such agreement regarding the right to review a treatment plan more frequently shall apply only to the particular Member being treated for an Autism Spectrum Disorder and shall not apply to all individuals being treated for Autism Spectrum Disorder by a Physician or psychologist. The cost of obtaining any review or treatment plan shall be borne by BlueLincs.

PSYCHIATRIC CARE SERVICES

We pay the scheduled amounts for the following Covered Services you receive from a Provider to treat Mental Health and Substance Use Disorder:

- Inpatient Facility Services

  Covered Inpatient Hospital Services provided by a Hospital, Psychiatric Hospital, Residential Treatment Center or other Plan-approved Provider (including partial hospitalization programs).

- 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 rendered 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

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

NOTE: Covered Services for treatment of Mental Health and Substance Use Disorder include those delivered through behavioral health integration and the psychiatric collaborative care model.

NOTE: You or your Provider may contact Customer Service at the number on the back of your Identification Card or visit our website at www.bcbsok.com for assistance with obtaining Covered Services for the treatment of Mental Health and Substance Use Disorders from a Non-Participating Provider at the In-Network Benefit level, if such care is not available from a Participating Provider within:

- 24 hours for emergency care;
- 7 days for residential or hospitalization care; or
- 30 days for all other care.

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*** appropriately equipped and staffed for treatment of the Member's condition. If none, you are covered for trips to the closest such facility outside your local area.
- Ambulance Services for non-Emergency Care may be covered when, in addition to the above requirements, the Member's condition is such that any other form of transportation would be medically contraindicated.
- Air ambulance services are covered only when:
  - Air ambulance services are Medically Necessary; and
  - Terrain, distance, your physical condition or other circumstances require the use of air ambulance services rather than ground ambulance services.

PRIVATE DUTY NURSING SERVICES

Services of a practicing RN, LPN or LVN when ordered by a Physician and when Medically Necessary. The nurse cannot be a member of your immediate family or usually live in your home.

Benefits for Private Duty Nursing Services are limited to the number of visits specified in the *Schedule of Benefits for Comprehensive Health Care Services* in the front of this Member Handbook.

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* in the front of this Member Handbook.

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* in the front of this Member Handbook.

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

We pay 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* in the front of this Member Handbook. 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 of a licensed registered dietitian or licensed certified nutritionist, when authorized by the patient's supervising Physician and when Medically Necessary, including but not limited to, diabetes self-management training.

We do not pay Home Health Care Benefits for:

- Homemaker services;
- Maintenance therapy;
- Speech Therapy;
- Durable Medical Equipment;
- Food or home-delivered meals;
- Infusion Therapy, **except when you have received Prior Authorization from BlueLincs 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.

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 Professional Provider:
  - Blood glucose monitors;
  - Blood glucose monitors to the legally blind;
  - Test strips for glucose monitors;
  - Visual reading and urine testing strips;
  - Insulin;
  - Injection aids;
  - Cartridges for the legally blind;

- Syringes;
- Insulin pumps and supplies;
- Insulin infusion devices;
- Oral agents for controlling blood sugar;
- Podiatric appliances for prevention of complications associated with diabetes; and
- Other diabetes equipment and related services that are determined Medically Necessary by the Oklahoma State Board of Health, provided such equipment and supplies have been approved by the federal Food and Drug Administration (FDA).

- Diabetes self-management training in an Inpatient or Outpatient setting which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalizations and complications. Diabetes self-management training must be conducted in accordance with the standards developed by the Oklahoma State Board of Health in consultation with a national diabetes association affiliated with this state and at least three medical directors of health benefit plans selected by the Oklahoma State Department of Health. Coverage for diabetes self-management training, including medical nutrition therapy relating to diet, caloric intake, and diabetes management (excluding programs the only purpose of which are weight reduction) shall be limited to the following:
  - Visits Medically Necessary upon the diagnosis of diabetes;
  - A Physician diagnosis which represents a significant change in the patient's symptoms or condition making Medically Necessary changes in the patient's self-management; and
  - Visits when re-education or refresher training is Medically Necessary.

  Benefits for diabetes self-management training in accordance with this provision shall be provided only when the patient has successfully completed the 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 **Schedule of Benefits** of this Member Handbook, including the ***Schedule of Benefits for Outpatient Prescription Drugs and Related Services***.

SERVICES RELATED TO CLINICAL TRIALS

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

- Any of the following federally funded or approved trials:
  - The Centers for Disease Control and Prevention of the United States Department of Health and Human Services;
  - The National Institutes of Health (NIH);
  - The Centers for Medicare and Medicaid Services;
  - The Agency for Healthcare Research and Quality;

- A cooperative group or center of any of the previous entities;
- The United States Food and Drug Administration;
- The United States Department of Defense (DOD);
- The United States Department of Veterans Affairs (VA);
- A qualified non-governmental research entity identified in guidelines issued by the NIH for center support grants or the DOD, VA or Department of Energy if the study has been reviewed and approved through a peer review system; or
- An institutional review board of an institution in this state that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services.

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

Benefits may not be available under this section for services that are paid for by the research institution conducting the clinical trial.

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

- The investigational item, device or service, itself;
- Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

DURABLE MEDICAL EQUIPMENT

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

- It is used in the Member's home, place of residence or dwelling;
- It provides therapeutic benefits or enables the Member 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 or Other Professional Provider and meets the BlueLincs'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 Member's home or vehicle.

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

NOTE: For Durable Medical Equipment and supplies obtained from an out-of-network Provider, either because your Provider deemed it necessary that you receive it within 24 hours, or because there was not a network Provider within 15 miles of your home address, the cost-sharing requirements will be the same as if they were obtained in-network.

PROSTHETIC APPLIANCES

Devices, along with pertinent supplies, which replace all or part of an absent body organ and which are Medically Necessary for the alleviation or correction of conditions arising out of bodily injury or illness covered by this Member Handbook. 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 determined to be 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.

The following devices are not covered, except as specified under *"Diabetes Equipment, Supplies and Self-Management Services"*:

- Arch supports and other foot support devices;
- Elastic/compression 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* in the front of this Member Handbook.

AUDIOLOGICAL SERVICES AND HEARING AIDS

Benefits will be provided to Members for audiological services, Cochlear Implants and hearing aids. Hearing aids must be prescribed, filled and dispensed by a licensed audiologist or other Provider acting within the scope of their license.

Benefits for audiological services and hearing aids are limited to the maximum amount specified in the *Schedule of Benefits for Comprehensive Health Care Services*.

WIGS OR OTHER SCALP PROSTHESES

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 for wigs or other scalp prostheses are limited to the maximum amount specified in the *Schedule of Benefits for Comprehensive Health Care Services*.

Outpatient Prescription Drugs and Related Services

Subject to the ***Exclusions***, conditions and limitations, a Member is entitled to the Benefits of this section for covered Outpatient Prescription Drugs and related services, subject to the Copayment, Coinsurance and/or Deductible amounts specified in the ***Schedule of Benefits for Outpatient Prescription Drugs and Related Services.***

Benefits for Prescription Drugs (if applicable) are provided only when dispensed by a Participating Retail Pharmacy, except in emergency situations as determined by BlueLincs.

PARTICIPATING PHARMACY NETWORK

For purposes of this ***Outpatient Prescription Drugs and Related Services*** section, a "Participating Pharmacy" or "Participating Retail Pharmacy" means a Pharmacy who has entered into an agreement to be a part of the BlueLincs Pharmacy Network.

To find a Pharmacy in the BlueLincs Pharmacy Network, please refer to our website at www.bcbsok.com or call BlueLincs Customer Service at the number shown on the back of your Identification Card.

BENEFITS

Benefits are provided for Outpatient Prescription Drugs and related services, limited to the following:

- Prescription Drugs are drugs that are required by federal and state law to be dispensed only by prescription.
- Benefits are provided for Prescription Drugs dispensed for a Member's use, provided such care and treatment is Medically Necessary and is a Covered Service in the ***Outpatient Prescription Drugs and Related Services*** section.
- Prescription Drugs dispensed for a Member's Outpatient use, when recommended by and while under the care of a Physician or Other Professional Provider.
- Benefits for Prescription Drugs are available to the Member only:
  - In accordance with a Prescription Order; and
  - After the Member has met the Deductibles, if applicable; and
  - After the Member has incurred charges equal to the Copayment or Coinsurance applicable to each Prescription Order. If the charge for the Member's prescription is less than the Copayment, the member will pay the lesser amount; and
  - When dispensed by a Participating Pharmacy (except in Emergency situations).

COVERED SERVICES

Benefits are provided for Outpatient Prescription Drugs and related services, limited to the following:

- Injectable insulin and insulin products, but only when dispensed in accordance with a written prescription by a licensed Physician or Other Professional Provider even though a prescription may not be required by law.
- Oral contraceptives, when prescribed by a licensed Physician or Other Professional Provider.
- Prescription Drugs prescribed for the treatment of attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD).

- Self-injectable and other self-administered Prescription Drugs (including Chemotherapy) when dispensed by a Pharmacy. Self-injectable and other self-administered drugs purchased from a Physician or Other Professional Provider and administered in his/her office are not covered. Many self-injectable/self-administered drugs are classified as "Specialty Pharmacy Drugs" and should be purchased from a Participating Specialty Pharmacy.
- Oral Chemotherapy when prescribed by a licensed Physician. Your Copayment, Coinsurance and/or Deductible amount will not apply to orally administered anticancer medications when received from a Participating Pharmacy. Coverage of prescribed orally administered anticancer medications will be provided on a basis no less favorable than intravenously administered or injected cancer medications.
- Specialty Pharmacy Drugs (when dispensed by a Pharmacy participating in the Specialty Pharmacy Network) are limited to a 30-day supply. However, some have FDA approved dosing regimens exceeding the 30-day supply limits and may be allowed greater than a 30-day supply. Benefits will be subject to the Copayment, Coinsurance and/or Deductible provisions.
- Select vaccinations administered by a Participating Retail Pharmacy Vaccination Network Provider. Visit the Blue Cross and Blue Shield of Oklahoma website at www.bcbsok.com for a current listing of vaccines available through this program. Vaccinations administered by a Participating Retail Pharmacy Vaccination Network Provider are not subject to the Copayment, Coinsurance and/or Deductible provisions of this Member Handbook.
- Drugs prescribed by a Physician or Other Professional Provider as part of "*Preventive Care Services*" as defined in this Handbook.

In order to be a Covered Drug under this ***Outpatient Prescription Drugs and Related Services*** section, the Prescription Drugs must be shown on the Drug List. The drugs on the Drug List have been selected to provide coverage for a broad range of diseases. Each drug appearing on the list shows to which tiered category it belongs. For example, most Generic Drugs are categorized as Tier 1 or Tier 2 drugs, while Specialty Drugs may be classified as Tier 5 or Tier 6 drugs (depending upon the benefit plan in which you are enrolled). You may refer to the ***Schedule of Benefits for Outpatient Prescription Drugs and Related Services*** to determine the level of coverage available for each drug tier/category.

- Tier 1 – includes mostly Generic Drugs (Preferred) and may contain some Brand Name Drugs.
- Tier 2 – includes mostly Generic Drugs (Non-Preferred) and may contain some Brand Name Drugs.
- Tier 3 – includes mostly Brand Name Drugs (Preferred) and may contain some Generic Drugs.
- Tier 4 – includes mostly Brand Name Drugs (Non-Preferred) and may contain some Generic Drugs.
- Tier 5 – includes mostly Specialty Drugs (Preferred) and may contain some Generic Drugs.
- Tier 6 – includes mostly Specialty Drugs (Non-Preferred) and may contain some Generic Drugs.

The Drug List is subject to periodic review and change by BlueLincs. A current list is available on our website at www.bcbsok.com. You may also contact a Customer Service Representative at the number shown on your Identification Card for more information.

As new drugs are approved by the Food and Drug Administration (FDA), such drugs, unless the intended use is specifically excluded under the Member Handbook, will be reviewed by BlueLincs and may be added to the applicable Drug List and be eligible for Benefits as outlined in the ***Schedule of Benefits for Outpatient Prescription Drugs and Related Services***.

You may not be required to pay the difference in cost between the Allowable Charge of the brand name drug and the Allowable Charge of the Generic Drug if there is a medical reason (e.g., adverse event) you need to take the brand name drug and certain criteria are met. Your Provider can submit a request to waive

the difference in cost between the Allowable Charge of the brand name drug and Allowable Charge of the Generic Drug. In order for this request to be reviewed, your Provider must send in a MedWatch form to the Food and Drug Administration (FDA) to let them know the issues you experienced with the generic equivalent. Your Physician or Other Professional Provider must provide a copy of this form when requesting the waiver. The FDA MedWatch form is used to document adverse events, therapeutic inequivalence/failure, product quality problems, and product use/medication error. This form is available on the FDA website. If the waiver is granted, applicable Copayment and/or Coinsurance amounts will still apply. For additional information, contact the customer service number on the back of your Identification Card or visit www.bcbsok.com.

RETAIL PHARMACY PROGRAM

The Benefits you receive and the amount you pay will vary depending upon the type of drugs or supplies obtained and whether they are obtained from a Preferred Participating Pharmacy, Participating Pharmacy or out-of-network Pharmacy. Your cost will be the appropriate Copayment, Coinsurance and/or Deductible amount indicated in the ***Schedule of Benefits for Outpatient Prescription Drugs and Related Services.***

Benefits for Prescription Drugs are provided only when dispensed by a Participating Pharmacy, except in emergency situations as determined by the Plan.

NOTE: The amount you may pay for a covered insulin drug shall not exceed $30 per 30-day supply or $90 per 90-day supply.

EXTENDED PRESCRIPTION DRUG SUPPLY PROGRAM

Your coverage includes Benefits for up to a 90-day supply of Prescription Drugs purchased from a Participating Pharmacy which may only include Preferred Participating retail or Participating Mail-Order pharmacies. Benefit amounts are listed in the ***Schedule of Benefits for Outpatient Prescription Drugs and Related Services.*** Your cost will be the appropriate Copayment, Coinsurance and/or Deductible amount indicated in the ***Schedule of Benefits for Outpatient Prescription Drugs and Related Services.***

Benefits will not be provided for more than a 30-day supply of drugs obtained from a Prescription Drug Provider *not* participating in the Extended Prescription Drug Supply Program.

NOTE: The amount you may pay for a covered insulin drug shall not exceed $30 per 30-day supply or $90 per 90-day supply.

MAIL-ORDER PHARMACY PROGRAM

The Plan has selected a Mail-Order Pharmacy Program to fill and deliver medications. This program provides delivery of Prescription Drugs directly to your home address. All items that are covered under the Mail-Order Pharmacy Program are subject to the same limitations and exclusions as the Retail Pharmacy Program. **Items covered through a Specialty Pharmacy are not covered through the Mail-Order Pharmacy Program.** NOTE: Prescription Drugs and other items may not be mailed outside the United States.

Some drugs may not be available through the Mail-Order Pharmacy Program. If you have any questions about this Mail-Order Pharmacy Program, need assistance in determining the amount of your payment or need to obtain the mail-order prescription form, you may access the website at www.bcbsok.com, or contact Customer Service at the toll-free number on your Identification Card. Mail the completed form, your Prescription Order(s) and payment to the address indicated on the form.

Your cost will be the appropriate Copayment, Coinsurance and/or Deductible amount indicated in the ***Schedule of Benefits for Outpatient Prescription Drugs and Related Services.***

If you send an incorrect payment amount for the Prescription Order dispensed, you will: (a) receive a credit if the payment is too much; or (b) be billed for the appropriate amount if it is not enough.

SPECIALTY PHARMACY DRUG PROGRAM

The Specialty Pharmacy Drug Program provides delivery of medications directly to your health care Provider for administration or to the home of the patient that is undergoing treatment for a complex medical condition. **Due to special storage requirements, Specialty Drugs are not covered unless obtained through the Specialty Pharmacy Drug Program, unless coverage is specifically provided elsewhere in this Member Handbook and/or is required by applicable law or regulation.**

The Specialty Pharmacy Drug Program delivery service offers:

- Coordination of coverage among you, your health care Provider and the Plan;
- Educational materials about the patient's particular condition and information about managing potential medication side effects;
- Syringes, sharps containers, alcohol swabs and other supplies with every shipment for FDA approved self-injectable/self-administered medications; and
- Access to a pharmacist for urgent medication issues 24 hours a day, seven days a week, 365 days each year.

Coverage for Specialty Drugs are limited to a 30-day supply. However, some Specialty Drugs have FDA approved dosing regimens exceeding the 30-day supply limits and may be allowed greater than a 30-day supply, if allowed by your Plan benefits. Cost share will be based on day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed.

Specialty Pharmacy Drugs are identified on the Drug List which is available by accessing the website at www.bcbsok.com or by contacting Customer Service at the toll-free number on your Identification Card. Your cost will be the appropriate Copayment, Coinsurance and/or Deductible amount indicated in the ***Schedule of Benefits for Outpatient Prescription Drugs and Related Services.***

If your Prescription Order is filled by a non-Participating Pharmacy, you will need to pay the full cost of the drugs directly to the Pharmacy and then submit a claim to BlueLincs in order to receive any Benefits under this program. In addition to any Copayment, Coinsurance and/or Deductible amounts applicable to your coverage, you will be responsible for the cost difference, if any, between the Pharmacy's billed charges and the Allowable Charge determined by BlueLincs.

MEDSYOURWAY™

MedsYourWay™ ("MedsYourWay") may lower your out-of-pocket costs for select Covered Drugs purchased at select Participating Retail Pharmacies. MedsYourWay is a program that automatically compares available drug discount card prices and prices under your Benefit plan for select Covered Drugs and establishes your out-of-pocket cost to the lower price available. At the time you submit or pick up your prescription, present your Identification Card to the pharmacist. This will identify you as a participant in MedsYourWay and allow you the lower price available for select Covered Drugs.

The amount you pay for your prescription will be applied, if applicable, to your Deductible, and Out-of-Pocket Limit. Available select Covered Drugs and drug discount card pricing through MedsYourWay may change occasionally. Certain restrictions may apply and certain Covered Drugs or discount cards may not be available for the MedsYourWay program. You may experience a different out-of-pocket amount for select Covered Drugs depending upon which retail pharmacy is utilized. For additional information regarding MedsYourWay, contact the customer service number on the back of your Identification Card or visit www.bcbsok.com. Participation in MedsYourWay is not mandatory and you may choose not to

participate in the program at any time by contacting customer service at the number on the back of your Identification Card or access Blue Access for Members℠ (BAM). In the event MedsYourWay fails to provide, or continue to provide, the program as stated, there will be no impact to you. In such an event, you will pay the amount shown in your ***Schedule of Benefits***.

LIMITATIONS ON BENEFITS

When Prescription Drugs are dispensed by a non-Participating Pharmacy, Benefits are limited to a three-day supply per Prescription Order in the case of Prescription Drugs for emergency conditions. BlueLincs reserves the right to determine what constitutes an emergency or Medical Necessity.

- In order for a Prescription Drug obtained from a non-Participating Pharmacy to be covered, the following criteria must be met:
  - The Member is outside the Service Area and the Physician or Other Professional Provider orders the Prescription Drug to treat a covered emergency condition (as determined by BlueLincs); or
  - The Member's Physician or Other Professional Provider orders the immediate use of a Prescription Drug due to a Medical Necessity, and no Participating Retail Pharmacy is open.
  - If your Prescription Order is filled by a non-Participating Pharmacy, you will need to pay the full cost of the drugs directly to the Pharmacy and then submit a claim to BlueLincs in order to receive any Benefits under this program. In addition to any Copayment, Coinsurance and/or Deductible amounts applicable to your coverage, you will be responsible for the cost difference, if any, between the Pharmacy's billed charges and the Allowable Charge determined by BlueLincs. **NOTE: Vaccinations administered by a Pharmacy that is not a Participating Retail Pharmacy Vaccination Network Provider are not covered under this *Outpatient Prescription Drugs and Related Services* section.**
- Benefits for Specialty Pharmacy Drugs dispensed by a Pharmacy that is not a member of the Specialty Pharmacy Network are limited to a three-day supply per Prescription Order, and are available only in the following instances:
  - You are outside the Service Area and the Physician or Other Professional Provider orders the Specialty Pharmacy Drug to treat a covered emergency condition (as determined by BlueLincs);
  - Your Physician or Other Professional Provider orders immediate use of a Specialty Pharmacy Drug due to a Medical Necessity and no Participating Specialty Pharmacy is open or available.

To receive reimbursement for emergency prescriptions, the Member must send BlueLincs the pharmacy receipt showing payment, name of the Prescription Drug, itemized cost, and a written statement regarding the circumstances of the emergency.

PRESCRIPTION DRUG SUPPLY/DISPENSING LIMITS

BlueLincs has the right to determine the day supply limits at its sole discretion. Benefits may be denied if drugs are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing, the stated maximum supply limitations.

- **Benefit Supply Limits per Prescription Order**

  For each Copayment or Coinsurance amount specified for your Outpatient Prescription Drugs, you can obtain the following supply of a single Prescription Drug or other item covered under this program (unless otherwise specified).

Benefits will be provided for Prescription Drugs dispensed in the following quantities:

- **Retail Pharmacy and Specialty Pharmacy Network Providers** - During each one-month period, up to a 30-day supply for Prescription Drugs. However, some Specialty Drugs have FDA approved dosing regimens exceeding the 30-day supply limits and may be allowed greater than a 30-day supply. Cost share will be based on day supply (1-30 day supply, 31-60 day supply, 61-90 day supply) dispensed.
- **Extended Retail Prescription Drug Supply Program and Mail-Order Pharmacy Program** - During each three-month period, up to a 90-day supply for Prescription Drugs.

Benefits are not provided under this Member Handbook for charges for Prescription Drugs dispensed in excess of the above stated amounts.

Benefits will not be provided for a prescription refill until 75% of the previous Prescription Order (or 70% for covered prescription eyedrops) has been used by the Member. An exception to this provision may be granted on at least one occasion per year to synchronize your Prescription Drug refills for certain covered Maintenance Prescription Drugs so that they are refilled on the same schedule (for a given time period). When necessary to permit synchronization, BlueLincs shall apply a prorated daily cost-sharing rate to any covered medication dispensed by a Participating Pharmacy. Some prescriptions may be subject to a shorter refill window. Please call Customer Service for details.

- **Multi-Category Split-Fill Program**

  If this is your first time using select medications in certain drug classes (e.g., medications for cancer, multiple sclerosis, lung disorders, etc.) or if you have not filled one of these medications within 120 days, you may only be able to receive a partial fill (14-15-day supply) of the medication for up to the first 3 months of therapy. This is to help see how the medication is working for you. If you receive a partial fill, your Copayments and/or Coinsurance after your Deductible will be adjusted to align with the quantity of medication dispensed. If the medication is working for you and your Physician or Other Professional Provider wants you to continue on this medication, you may be eligible to receive up to a 30-day supply after completing up to 3 months of the partial supply. For a list of drugs that are included in this program, visit our website at www.bcbsok.com/rx-drugs/pharmacy/pharmacy-programs.

- **Clinical Dispensing Limits Applicable to Certain Drugs**

  In addition to the supply limits stated above and regardless of the quantity of a Covered Drug prescribed by a Physician or Other Professional Provider, BlueLincs has the right to establish dispensing limits on Covered Drugs. These limits, which are based upon FDA dosing recommendations and nationally recognized clinical guidelines, or age restrictions, and/or the maximum quantity of a drug (or member of a drug class) that can be dispensed to you over a specific period of time. Such limits are in place to encourage appropriate drug use, patient safety, and reduce stockpiling. Benefits for a Covered Drug may also be denied if the drug is dispensed or delivered in a manner intended to avoid BlueLincs-established dispensing limit. If you need a drug quantity that exceeds the dispensing limit, ask your doctor to submit a request for review to BlueLincs on your behalf. The request will be approved or denied after the clinical information submitted by the prescribing doctor has been evaluated by BlueLincs.

- **Controlled Substances Limitation**

  If BlueLincs determines that a Member may be receiving quantities of controlled substance medications not supported by FDA-approved dosages or recognized safety or treatment guidelines, any coverage for additional drugs may be subject to a review for Medical Necessity, appropriateness and other coverage restrictions which may include but not limited to limiting coverage to services provided by a certain Provider and/or Pharmacy for the prescribing and dispensing of the controlled substance medication and/or limiting coverage to certain quantities. Additional Copayments and/or Coinsurance

may apply. For the purposes of this provision, controlled substance medications are medications classified and restricted by state or federal laws.

THERAPEUTIC EQUIVALENT RESTRICTIONS

Some drugs have therapeutic equivalents/therapeutic alternatives. In some cases, BlueLincs may limit Benefits to only certain therapeutic equivalents/therapeutic alternatives. If you do not choose the therapeutic equivalents/therapeutic alternatives that are covered under your Benefit, the drug purchased will not be covered under any Benefit level.

EXCLUSIONS AND LIMITATIONS

In addition to the exclusions and limitations specified in the ***Exclusions*** section of this Member Handbook and any ***Schedule of Benefits***, no Benefits will be provided under this ***Outpatient Prescription Drugs and Related Services*** section for:

- Drugs/products which are not included on the Drug List, unless specifically covered elsewhere in this Member Handbook and/or such coverage is required in accordance with applicable law or regulatory guidance.
- Non-FDA approved drugs.
- Drugs that are not considered Medically Necessary or treatment recommendations that are not supported by evidence-based guidelines or clinical practice guidelines.
- Drugs which by law do not require a Prescription Order from an authorized Provider (except insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar level); and drugs, insulin or covered devices for which no valid Prescription Order is obtained.
- Non-prescription drugs (including over-the-counter items) except as specified under *"Preventive Care Services"* in the ***Comprehensive Health Care Services*** section of this Handbook.
- Devices, technologies, and/or Durable Medical Equipment of any type (even though such devices may require a Prescription Order), such as, but not limited to, therapeutic devices, artificial appliances, digital health technologies and/or applications, or similar devices (**except** disposable hypodermic needles and syringes for self-administered injections).
- Pharmaceutical aids such as excipients found in the USP-NF (United States Pharmacopeia-National Formulary) including but not limited to, preservatives, solvents, ointment bases, and flavoring, coloring, diluting, emulsifying and suspending agents.
- Administration or injection of any drugs (except for select vaccines administered by a Participating Pharmacy).
- Vitamins (**except** those vitamins which by law require a Prescription Order and for which there is **no** non-prescription alternative).
- Drugs dispensed in a Physician or Other Professional Provider's office or during confinement while a patient in a Hospital, or other acute care institution or facility, including take-home drugs; and drugs dispensed by a nursing home or custodial or chronic care institution or facility.
- Covered Drugs, devices, or other Pharmacy services or supplies for which benefits are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States (including but not limited to, any services or supplies for which benefits are payable under Part A and Part B of Title XVIII of the Social Security Act (Medicare), or the laws, regulations or established procedures of any county or municipality, except any program which is a state plan for medical assistance (Medicaid), or any Prescription Drug which may be properly

obtained without charge under local, state, or federal programs, unless such exclusion is expressly prohibited by law; provided, however, that this exclusion shall not be applicable to any coverage held by you for Prescription Drug expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.

- Any services provided or items furnished for which the Pharmacy normally does not charge.
- Infertility and fertility medications, except medications for Standard Fertility Preservation Services related to Iatrogenic Infertility.
- Prescription contraceptive devices or non-prescription contraceptive materials (**except** oral contraceptive medications which are Prescription Drugs). However, coverage for prescription contraceptive devices is provided under the medical benefits provisions of your Member Handbook.
- Drugs required by law to be labeled: "Caution — Limited by Federal Law to Investigational Use", or Experimental, Investigational and/or Unproven drugs, even though a charge is made for the drugs.
- Covered Drugs or devices dispensed in quantities in excess of the amounts stipulated in this ***Outpatient Prescription Drugs and Related Services*** section; or refills of any prescriptions in excess of the number of refills specified by the Physician or Other Professional Provider or by law; or any drugs or medicines dispensed more than one year following the Prescription Order date.
- Fluids, solutions, nutrients, medications (including all additives and Chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous, intramuscular (in the muscle), intrathecal (in the spine), or intraarticular (in the joint) injection in the home setting, except as specifically provided in your Member Handbook and its Schedule(s) of Benefits. NOTE: This exception does not apply to dietary formula necessary for the treatment of phenylketonuria (PKU) or other heritable diseases.
- Drugs prescribed and dispensed for the treatment of obesity or for use in any program of weight reduction, weight loss, or dietary control.
- Drugs for the use or intended use of which would be illegal, unethical, imprudent, abusive, not Medically Necessary, or otherwise improper.
- Drugs obtained by unauthorized, fraudulent, abusive, or improper use of the Identification Card.
- Rogaine, Minoxidil or any other drugs, medications, solutions, devices or preparations used or intended for use in the treatment of hair loss, hair thinning or any related condition, whether to facilitate or promote hair growth, to replace lost hair, or otherwise.
- Cosmetic drugs used primarily to enhance appearance, including but not limited to, correction of skin wrinkles and skin aging.
- Prescription Orders for which there is an over-the-counter product available with the same active ingredient(s), in the same strength, unless otherwise determined by BlueLincs.
- Athletic performance enhancement drugs.
- Drugs to treat sexual dysfunction or male erectile dysfunction, including but not limited to, sildenafil citrate (Viagra), phentolamine (Regitine), alprostadil (Prostin, Edex, Caverject), and apomorphine.
- Compounded medications. For purposes of this exclusion, "compounded medications" are customized medications made by mixing, assembling, packaging, or labeling drugs that are not commercially available in a specific dosage form, strength or formulation.
- Replacement of drugs or other items that have been lost, stolen, destroyed, or misplaced.
- Shipping, handling, or delivery charges.

- Certain drug classes where there are over-the-counter alternatives available.
- Non-sedating antihistamine drugs and combination medications containing a non-sedating antihistamine and decongestant.
- Brand name proton pump inhibitors.
- Re-packagers, institutional packs, clinic packs, or other custom packaging.
- Drugs determined by BlueLincs to have inferior efficacy or significant safety issues.
- Diagnostic agents, except diabetic testing supplies or test strips.
- Bulk powders.
- Any self-injectable and other self-administered drugs purchased from a Physician or Other Professional Provider and administered in his/her office.
- Cannabis, meaning all parts of the plant genus Cannabis containing delta-9-tetrahydrocannabinol (THC) as an active ingredient, whether growing or not, the seeds of the plant, the resin extracted from any part of the plant, and every cannabis-derived compound, manufacture, salt, derivative, mixture or preparation of the plant, its seeds or its resin. Cannabis with THC as an active ingredient may be called marijuana.
- New-to-market FDA-approved drugs which are subject to review by Prime Therapeutics Pharmacy and Therapeutic (P&T) Committee prior to coverage of the drug.

PRESCRIPTION DRUG PRIOR AUTHORIZATION AND STEP THERAPY PROCESS

BlueLincs has designated certain drugs which require Prior Authorization in order for Benefits to be provided under the *Schedule of Benefits for Outpatient Prescription Drugs and Related Services* supplement. Prior Authorization means that in order to determine that a drug is safe, effective, and part of a specific treatment plan, certain medications may require Prior Authorization and the evaluation of additional clinical information and criteria before the drug is covered under your Prescription Drug program.

A Step Therapy program is a "step" approach to providing Benefits for certain medications your Physician or Other Professional Provider prescribes for you. This means that you may first need to try one or more "prerequisite" clinically acceptable alternative medications before certain medications identified on the Step Therapy Drug List are approved for coverage under your Prescription Drug program. Although you may currently be on therapy, your claim may need to be reviewed to see if the criteria for coverage of further treatment has been met. A documented treatment with a prerequisite medication or other exception may be required for continued coverage of the drug identified on the Step Therapy Drug List. Please refer to the *"Step Therapy Exception Requests"* in this ***Outpatient Prescription Drugs and Related Services*** for information regarding exception requests.

You can obtain a listing of the drugs which require Prior Authorization or Step Therapy by visiting our website at www.bcbsok.com, or you may contact BlueLincs Customer Service at the number shown on your Identification Card. Also, you may request a listing by writing to:

BlueLincs HMO
Customer Service Department
PO Box 655924
Dallas, TX 75265-5924

Please keep in mind that the listing of drugs requiring Prior Authorization or Step Therapy will change periodically as new drugs are developed or as required to assure Medical Necessity.

If your Physician or Other Professional Provider prescribes a drug which requires prior approval, you, the Physician or Other Professional Provider may request a Prior Authorization review or a Step Therapy exception by calling the BlueLincs Customer Service number shown on your Identification Card or visiting our website at www.bcbsok.com. Your request will be reviewed within the required time frames. If you have a health condition that may jeopardize your life, health or keep you from regaining function, you or your Provider may be able to ask for an expedited review process.

When you present your Prescription Order to a Participating Retail Pharmacy, along with your BlueLincs Identification Card, the pharmacist will submit an electronic claim to BlueLincs to determine the appropriate Benefits.

If the Prior Authorization or Step Therapy exception request is approved, your pharmacist will dispense the Prescription Drug as prescribed and collect any applicable Copayment, Coinsurance and/or Deductible amounts.

If the Prior Authorization or Step Therapy exception request is denied, you will be responsible for the full cost of your prescription.

If you purchase your prescriptions from an out-of-network (non-Participating) Pharmacy, or if you do not have your Identification Card with you at the time of purchase at a Participating Retail Pharmacy, you will be responsible for paying the full cost of the Prescription Order. Benefits for Prescription Drugs are provided only when dispensed by a Participating Retail Pharmacy, except in emergency situations as determined by BlueLincs.

If you present your Prescription Order to a Participating Retail Pharmacy and the electronic system is unavailable to determine the appropriate Benefits, you should pay the Participating Retail Pharmacy for the Prescription Order. To receive reimbursement, you must submit a written request, along with the Participating Retail Pharmacy's itemized statement to:

Prime Therapeutics
PO Box 25136
Lehigh Valley, PA 18002-5136

To view a listing of the drugs which are included in the Prior Authorization or Step Therapy program, please visit our website at www.bcbsok.com. If you have questions about Step Therapy or Prior Authorization process, please call the number shown on your Identification Card for assistance.

STEP THERAPY EXCEPTION REQUESTS

You or your Provider can ask for a Step Therapy exception. To request this exception, you or your Provider can call the number on the back of your Identification Card or visit our website at www.bcbsok.com to ask for a review. BlueLincs will respond to you and your Provider within 72 hours after the Plan receives your request. If the timeframe for a response ends on a weekend or a legal holiday, the timeframe for the response shall run until the close of the next full business day. If the prescribing Provider indicates that you have a health condition that may jeopardize your life, health or keep you from regaining function, we will respond to such request within 24 hours after the Plan receives your request. If the timeframe for a response ends on a weekend or a legal holiday, the timeframe for the response shall run until the close of the next full business day. If we fail to respond within the required time, the Step Therapy exception or request shall be deemed granted. If the request is denied, we will let you and your Provider know why it was denied. If your exception is denied, you may appeal the decision according to the appeals process you will receive with the denial determination. Call the number on the back of your Identification Card if you have any questions.

DRUG LIST EXCEPTION REQUESTS

You or your Provider can ask for a Drug List exception if your drug is not on the Drug List. To request this exception, you or your Provider can call the number on the back of your Identification Card to ask for a review. If you have a health condition that may jeopardize your life, health or keep you from regaining function, or your current drug therapy uses a non-Covered Drug, you or your Provider may be able to ask for an expedited review process. BlueLincs will let you and your Provider know the coverage decision within 72 hours after the Plan receives your request for an expedited review. If the coverage request is denied, we will let you and your Provider know why it was denied and offer you a covered alternative drug (if applicable). If your exception is denied, the denial determination will include information explaining the appeals process, which includes your right to request review by an Independent Review Organization. Call the number on the back of your Identification Card if you have any questions.

TERMINATION OF BENEFITS

When you cease to be eligible for coverage, as defined in the Agreement, ***Outpatient Prescription Drugs and Related Services*** will end on the effective date and time of your termination. In the event you purchase Prescription Drugs from a Participating Retail Pharmacy after the date of your termination, you shall be required to reimburse BlueLincs for any Benefits it has paid and for which you were not eligible under the terms of the Agreement.

In the event BlueLincs receives notification of the Group's intent to terminate the Agreement, Benefits for Prescription Drugs dispensed on or after that date will be limited to a 30-day supply for all Members covered under the Agreement.

Exclusions

The following services or procedures are not covered by BlueLincs HMO:

- Services BlueLincs determines are not Medically Necessary.
- Non-emergency services that are not authorized by the Member's Primary Care Provider (PCP).
- Services received prior to the Effective Date of coverage.
- Services received after the coverage stops.
- Services which BlueLincs determines are Experimental, Investigational and/or Unproven in nature.
- Any condition to the extent benefits would have been provided under Medicare or to the extent governmental units provide benefits (some state or federal laws may affect how this exclusion is applied).
- Physical examinations for obtaining or for continuing employment, insurance, government licensing, flight, camp, school or athletics, or immunizations for international travel.
- Testing of:
  - blood for measurement of levels of: Lipoprotein a; small dense low-density lipoprotein; lipoprotein subclass high resolution; lipoprotein subclass particle numbers; lipoprotein associated phospholipase A2, which are fat/protein substances in the blood;
  - urine for measurement of collagen cross links;
  - cervicovaginal fluid for amniotic fluid protein;
  - allergen specific IgG measurement.
- The diagnosis, treatment or medications for infertility and fertilization procedures, except for artificial insemination and Standard Fertility Preservation Services related to Iatrogenic Infertility.
- Cosmetic Surgery or complications resulting therefrom, including Surgery to improve or restore personal 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 or other Medically Necessary procedure.
- Hearing aids, except as specified under "Audiological Services and Hearing Aids".
- 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.
- Repair and/or replacement of Durable Medical Equipment which is lost, damaged or destroyed due to improper use or abuse.
- Refractions, including lens prescriptions, corrective eyeglasses and frames, contact lenses (including the fitting of the lenses), or toric or accommodating intraocular lens implants except as may be

specifically provided for in the ***Schedule of Benefits for Comprehensive Health Care Services***. Refractive Surgery is excluded.

- Scanning the visible front portion of the eye with computerized ophthalmic diagnostic imaging or measuring the firmness of the front of the eye with corneal hysteresis by air impulse stimulation.
- Expenses for or related to transplantation of donor organs, tissues or bone marrow, except as specified under *"Human Organ, Tissue and Bone Marrow Transplant Services"*.
- Collection and storage of blood products or tissues.
- Custodial Care such as sitters' or homemakers' services, or care in a place that services you primarily as a residence when you do not require skilled nursing.
- Personal hygiene and convenience items regardless of whether or not recommended by a Physician or other Provider. Examples include but are not limited to: computers; air conditioners, air purifiers or filters; humidifiers; or physical fitness equipment, including exercise bicycles or treadmills; or modifications to your home or vehicle.
- Care provided outside the Service Area if the need for care could have been foreseen before departing the Service Area.
- Medical and Hospital costs resulting from a normal, full-term delivery of a baby outside of the BlueLincs Provider network.
- For or related to Inpatient treatment of 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 who has a medical or emotional condition which requires hospitalization or general anesthesia for dental care; or who, in the judgement of the practitioner, is not of sufficient emotional development to undergo a Medically Necessary dental procedure without the use of anesthesia.
- 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;
  - the improvement of the physiological functioning of a malformed body member resulting from a congenital defect;
  - dental extractions performed in preparation for radiation treatment for neoplasms involving the jaw/mouth; or
  - dental extractions of diseased teeth prior to a solid organ transplant.
- Dental implants or associated procedure or for any complications arising from such procedures.
- Inpatient or Outpatient care which is necessitated in whole or in part by a non-covered condition or service.
- Medical supplies such as dressings, antiseptic, needles, syringes (except for diabetics) and other over-the-counter items.
- 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; bariatric Surgery or other surgical procedures for weight reduction; 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.

- Nutritional products, including supplements or replacements, for enteral or oral intake.
- 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.
- Acupuncture, whether for medical or anesthesia purposes, dry needling, or trigger-point acupuncture.
- Physician standby services.
- Health care services provided by an immediate family member.
- Charges for failure to keep a scheduled visit, or charges for completion of a claim form.
- Hippotherapy, equine assisted learning, or other therapeutic riding programs.
- Continuous Passive Motion (CPM) devices used in treatment of the shoulder or other joints, except for up to 21 days postoperatively for certain knee procedures determined to be Medically Necessary per our medical policy.
- Services or supplies for:
  - intersegmental traction;
  - all types of bone traction devices and equipment;
  - vertebral axial decompression sessions;
  - surface EMGs; which is measurement of muscle electrical activity with electrodes placed on the skin over them;
  - spinal manipulation under anesthesia;
  - muscle testing through computerized kinesiology machines;
  - balance testing through computerized dynamic posturography sensory organization test.
- Treatment of decreased blood flow to the legs with pneumatic compression device high pressure rapid inflation deflation cycle, or treatment of tissue damage in any location with platelet-rich plasma.
- Treatment of tissue damage or disease in any location with platelet-rich plasma.
- Ductal lavage of the mammary ducts.
- Human donor milk.
- Extracorporeal shock wave treatment, also known as orthotripsy, using either a high- or low-dose protocol, for treatment of plantar fasciitis and all other musculoskeletal conditions.
- Orthoptic training.
- Thermal capsulorrhaphy as a treatment of joint instability, including, but not limited to, instability of shoulders, knees and elbows.
- Transcutaneous electrical nerve stimulator (TENS).
- Transportation services, except as described under *"Ambulance Services"* in the ***Comprehensive Health Care Services*** section of this Member Handbook.

- Inpatient substance use treatment that is not rendered in a Hospital, Psychiatric Hospital, Residential Treatment Center or other Plan-approved Provider.
- Massage therapy, including but not limited to, effleurage, petrissage and/or tapotement.
- Tobacco cessation programs (not including counseling as specified under *"Preventive Care Services"*).
- Unspecified developmental disorders that are not related to a specified medical condition, except as described in the ***Comprehensive Health Care Services*** section under *"Services Related to Treatment of Autism Spectrum Disorder"*.
- For or related to Applied Behavior Analysis, except for the treatment of Autism Spectrum Disorder as described in the ***Comprehensive Health Care Services*** section under "*Services Related to Treatment of Autism Spectrum Disorder"*.
- Female contraceptive devices when not prescribed by a licensed Provider, including over-the-counter contraceptive products.
- For or related to the planned delivery of a newborn child at home, or in any setting other than a Hospital, licensed birthing center or other facility licensed to provide such services.
- Elective abortion, unless the life of the mother is endangered.
- Any self-injectable and other self-administered drugs purchased from a Physician or Other Professional Provider and administered in his/her office.
- Any services related to a non-Covered Service. Related services are:
  - services in preparation for the non-Covered Service;
  - services in connection with providing the non-Covered Service;
  - hospitalization required to perform the non-Covered Service; or
  - services that are usually provided following the non-Covered Service, such as follow-up care or therapy after Surgery.
- Cannabis, meaning all parts of the plant genus Cannabis containing delta-9-tetrahydrocannabinol (THC) as an active ingredient, whether growing or not, the seeds of the plant, the resin extracted from any part of the plant, and every cannabis-derived compound, manufacture, salt, derivative, mixture or preparation of the plant, its seeds or its resin. Cannabis with THC as an active ingredient may be called marijuana.
- Which are not specifically named as Covered Services subject to any other specific exclusions and limitations in this Member Handbook.

General Provisions

COST SHARING FEATURES OF YOUR COVERAGE

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

FEDERAL BALANCE BILLING AND OTHER PROTECTIONS

This section is based upon the No Surprises Act, a federal law enacted in 2020 and effective for plan years beginning on or after January 1, 2022. Unless otherwise required by federal or Oklahoma law, if there is a conflict between the terms of this "*Federal Balance Billing and Other Protections"* section and the terms in the rest of this Member Handbook, the terms of this section will apply. However, definitions set forth in the "*Federal No Surprises Act Definitions*" provision of this section are for purposes of this section only.

I. Continuity of Care

If you are under the care of a Participating Provider as defined in this Member Handbook who stops participating in the Plan's network (for reasons other than failure to meet applicable quality standards, including medical incompetence or professional behavior, or fraud), you may be able to continue coverage for that Provider's Covered Services at the Participating Provider benefit level if one of the following conditions is met:

- you are undergoing a course of treatment for a serious and complex condition;
- you are undergoing institutional or Inpatient care;
- you are scheduled to undergo non-elective Surgery from the Provider (including receipt of post-operative care from such Provider with respect to such Surgery);
- you are pregnant or undergoing a course of treatment for your pregnancy; or
- you are determined to be terminally ill.

A serious and complex condition is one that (1) for an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm (for example, if you are currently receiving Chemotherapy, Radiation Therapy, or post-operative visits for a serious acute disease or condition), and (2) for a chronic illness or condition, is (i) life-threatening, degenerative, disabling or potentially disabling, or congenital, and (ii) requires specialized medical care over a prolonged period of time.

Continuity coverage described in this provision shall continue until the treatment is complete but will not extend for more than 90 days beyond the date BlueLincs notifies you of the Provider's termination, or any longer period provided by state law. If you are in the second or third trimester of pregnancy when the Provider's termination takes effect, continuity of coverage may be extended through delivery of the child, immediate postpartum care, and the follow-up check-up within the first six (6) weeks of delivery. You have the right to appeal any decision made for a request for Benefits under this provision, as explained in the ***Member Complaints and Appeals*** section of this Member Handbook.

II. Federal No Surprises Act Definitions

The definitions below apply only to this "Federal Balance Billing and Other Protections" section. To the extent the same terms are defined in both the ***Definitions*** section of this Member Handbook, those terms will apply only to their use in the Handbook or this "Federal Balance Billing and Other Protections" section, respectively.

"Air Ambulance Services" means, for purposes of this section only, medical transport by helicopter or airplane for patients.

"Emergency Medical Condition" means, for purposes of this section only, a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition: (i) placing the health of the individual, or with respect to a pregnant woman her unborn child, in serious jeopardy; (ii) constituting a serious impairment to bodily functions; or (iii) constituting a serious dysfunction of any bodily organ or part.

"Emergency Services" means, for purposes of this section only:

- a medical screening examination performed in the emergency department of a Hospital or a freestanding emergency department;
- further medical examination or treatment you receive at a Hospital, regardless of the department of the Hospital, or a freestanding emergency department to evaluate and treat an emergency medical condition until your condition is stabilized; and
- Covered Services you receive from a Non-Participating Provider during the same visit after your emergency medical condition has stabilized unless:
    1. your Non-Participating Provider determines you can travel by non-medical or non-emergency transport;
    2. your Non-Participating Provider has provided you with a notice to consent form for balance billing of services; and
    3. you have provided informed consent.

"Non-Participating Provider" means, for purposes of this section only, with respect to a covered item or service, a Physician or other health care Provider who does not have a contractual relationship with BlueLincs for furnishing such item or service under the Plan.

"Non-Participating Emergency Facility" means, for purposes of this section only, with respect to a covered item or service, an emergency department of a Hospital or an independent freestanding emergency department that does not have a contractual relationship with BlueLincs for furnishing such item or service under the Plan.

"Participating Provider" means, for purposes of this section only, with respect to a Covered Service, a Physician or other health care Provider who has a contractual relationship with BlueLincs setting a rate (above which the Provider cannot bill the Member) for furnishing such item or service under the Plan to which this amendment is attached regardless of whether the Provider is considered a preferred or in-network Provider for purposes of in-network or out-of-network Benefits under the subject Plan.

"Participating Facility" means, for purposes of this section only, with respect to a Covered Service, a Hospital or ambulatory surgical center that has a contractual relationship with BlueLincs setting a rate (above which the Provider cannot bill the Member) for furnishing such item or service under the Plan, regardless of whether the Provider is considered a preferred or in-network Provider for purposes of in-network or out-of-network Benefits under the subject Plan.

"Qualifying Payment Amount" means, for purposes of this section only, a median of contracted rates calculated pursuant to federal or state law, regulation and/or guidance.

"Recognized Amount" means, for purposes of this section only, an amount determined pursuant a state law that provides a method for determining the total amount payable for the item or service (if applicable); or, if there is no state law that provides a method for determining the total amount payable for the item or service, the lesser of the Qualifying Payment Amount or billed charges.

III. Federal No Surprises Act Surprise Billing Protections

The federal No Surprises Act contains various protections relating to surprise medical bills on services performed by Non-Participating Providers and Non-Participating Emergency Facilities. The items and services included in these protections ("Included Services") are listed below.

- Emergency Services obtained from a Non-Participating Provider or Non-Participating Emergency Facility.
- Covered non-Emergency Services performed by a Non-Participating Provider at a Participating Facility (unless you give written consent and give up balance billing protections).
- Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider.

Claim Payments

For Included Services, the Plan will send an initial payment or notice of denial of payment directly to the Provider.

Cost-Sharing

For non-Emergency Services performed by Non-Participating Providers at a Participating Facility, and for Emergency Services provided by a Non-Participating Provider or Non-Participating Emergency Facility, the Recognized Amount is used to calculate your cost share requirements, including Deductibles, Copayments, and Coinsurance.

For Air Ambulance Services received from a Non-Participating Provider, if the services would be covered if received from a Participating Provider, the amount used to calculate your cost share requirements, including Deductibles, Copayments, and Coinsurance, will be the lesser of the Qualifying Payment Amount or billed charges.

For Included Services, these cost share requirements will be counted toward your Participating Provider Deductible and/or Out-of-Pocket Limit, if any.

IV. Prohibition of Balance Billing

You are protected from balance billing on Included Services as set forth below.

If you receive Emergency Services from a Non-Participating Provider or non-Participating Emergency Facility, the most the Non-Participating Provider or non-Participating Emergency Facility may bill you is your in-network cost share. You cannot be balance billed for these Emergency Services unless you give written consent and give up your protections not to be balanced billed for services you receive after you are in a stable condition.

When you receive covered Non-Emergency Services from a Non-Participating Provider at a Participating Facility, the most those Non-Participating Providers may bill you is your Plan's in-network cost share requirements. When you receive emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services at a Participating Facility, Non-Participating Providers can't balance bill you and may not ask you to give up your protections not to be balance billed. If you get other services at Participating Facilities, Non-

Participating Providers can't balance bill you unless you give written consent and give up your protections.

If your Plan includes Air Ambulance Services as a Covered Service, and such services are provided by a Non-Participating Provider, the most the Non-Participating Provider may bill you is your in-network cost share. You cannot be balance billed for these Air Ambulance Services.

LIMITATION OF ACTIONS

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

ASSIGNMENT OF BENEFITS

All rights of Members to receive Benefits for Covered Services are personal to the Member and may not be assigned to anyone else.

DETERMINATION OF BENEFITS ELIGIBILITY

BlueLincs, as claims administrator, is hereby granted discretionary authority to interpret the terms and conditions of the Agreement and to determine its Benefits.

In determining whether services or supplies are Covered Services, BlueLincs will determine whether a service or supply is Medically Necessary under the Agreement or if such service or supply is Experimental, Investigational and/or Unproven. BlueLincs 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 BlueLincs upon request and may be found online at www.bcbsok.com.

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

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

To assist BlueLincs in its review of your claims, we may request that:

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

Failure of the Member to comply with BlueLincs's request for medical records or medical evaluation may result in Benefits being partially or wholly denied.

ALLOWABLE CHARGE

The following method will be used for determining the Allowable Charge for Emergency Care Services received from Providers who do not have a Participating Provider agreement with BlueLincs

(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. BlueLincs' 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 BlueLincs. Such factor will not be less than 60% of the base Medicare reimbursement rate. However, in no event will the reimbursement exceed 90% of the lowest amount BlueLincs would have paid a network Provider for the same services.

  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 Participating Providers adjusted by a predetermined factor established by BlueLincs and updated on a periodic basis. Such factor shall not be less than 100% of the average contract rate. BlueLincs 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 BlueLincs does not have any claim edits or rules, BlueLincs 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 BlueLincs 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 Copayment, Coinsurance and/or Deductible amount. This difference may be considerable. To find out an estimate of BlueLincs' Non-Contracting Allowable Charge for a particular service, you may call the Customer Service number shown on the back of your Identification Card.

  Please refer to "*Out of Area Services*" below for information regarding Covered Services received from non-Participating Providers outside the BlueLincs Service Area.

- Whenever services are received from a non-Participating Provider, you will be responsible for the following:
  - Charges for any services which are not covered under your plan.
  - Any Coinsurance amounts that are applicable to your coverage.
  - The difference, if any, between your Provider's billed charges and the Allowable Charge determined by the Host Plan.

OUT-OF-AREA SERVICES

BlueLincs HMO has relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements". These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross and Blue Shield Association ("Association"). Whenever you obtain health care services outside the state of Oklahoma, the claims for these services may be processed through one of these Inter-Plan Arrangements.

Typically, when accessing care outside the state of Oklahoma, you will obtain care from health care

Providers that have a contractual agreement (i.e., are "Participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, you may obtain care from non-Participating Providers. Our reimbursement practices in both instances are described below.

Please note: The BlueLincs HMO Service Area is smaller than the Blue Cross and Blue Shield of Oklahoma Service Area; the BlueCard Program applies only outside of the Blue Cross and Blue Shield of Oklahoma Service Area. BlueLincs covers only limited health care services received outside of the BlueLincs Service Area. As used in this section, "Out-of-Area Covered Services" include Emergency Care or Urgent Care obtained outside the geographic area we serve. Follow-up care following an emergency is also available, provided Prior Authorization has been obtained for the services by BlueLincs. Any other services will not be eligible for Benefits unless authorized by BlueLincs.

- **BlueCard® Program**

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

  The BlueCard Program enables you to obtain Covered Services, as defined above, from a health care Provider participating with a Host Blue, where available. The Participating Provider will automatically file a claim for the services provided to you, so there are no claim forms for you to fill out. You will be responsible for the Member Copayment, Coinsurance and/or Deductible amount, as stated in your Member Handbook and the ***Schedule of Benefits***.

  Whenever you receive Covered Services outside our Service Area and the claim is processed through the BlueCard Program, the amount you pay for Covered Services is calculated based on the lower of:

  – The billed charges for your Covered Services; or

  – The negotiated price that the Host Blue makes available to us.

  Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your health care Provider. Sometimes, it is an estimated price that takes into account special arrangements with your health care Provider or Provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of health care Providers after taking into account the same types of transactions as with an estimated price.

  Estimated pricing and average pricing 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.

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

- **Non-Participating Providers Outside the BlueLincs Service Area**

  – **Liability Calculation**

    In general, when Covered Services are provided outside of the BlueLincs' Service Area by non-Participating Providers, the amount(s) a Member pays for such services will be calculated using the methodology described in the Agreement for non-Participating Providers located inside our Service Area. You may be responsible for the difference between the amount that the non-

Participating Provider bills and the payment BlueLincs 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.

– **Exceptions**

In some exception cases, BlueLincs 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 BlueLincs may make a payment based on the lesser of:

- the amount calculated using the methodology described in the Agreement 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 difference between the amount that the non-Participating Provider bills and the payment BlueLincs will make for the Covered Services as set forth above.

- **Blue Cross 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 Blue Cross Blue Shield Global Core when accessing Emergency Care Services and Urgent Care. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although 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 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, will arrange a Physician or Other Provider appointment or hospitalization, if necessary.

– **Emergency Care Services**

This Agreement covers only limited health care services received outside of the United States. As used in this section, "Out-of-Area Covered Services" include Emergency Care and Urgent Care obtained outside the geographic area we serve. Follow-up care following an emergency is also available, provided Prior Authorization has been obtained for the services by BlueLincs. Any other services will not be eligible for Benefits unless authorized by BlueLincs.

– **Inpatient Services**

In most cases, if you contact the service center for assistance, Hospitals will not require you to pay for covered Inpatient services, except for your Deductibles, Coinsurance and/or Copayments, 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 BlueLincs to obtain Prior Authorization for non-emergency Inpatient 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 claim 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 BlueLincs, the service center or online at www.bcbsglobalcore.com. If you need assistance with your claim 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: BlueLincs may postpone or waive application of any Copayment, Coinsurance and/or Deductible whenever it is necessary in order to obtain Provider discounts for Covered Services you receive outside the state of Oklahoma.

MEMBER DATA SHARING

You may, under certain circumstances, as specified below, apply for and obtain, subject to any applicable terms and conditions, replacement coverage. The replacement coverage will be that which is offered by BlueLincs, a division of Health Care Service Corporation, or, if you do not reside in the BlueLincs Service Area, by the Host Blue whose service area covers the geographic area in which you reside. The circumstances mentioned above may arise in various circumstances, such as from involuntary termination of your health coverage sponsored by the Employer. As part of the overall plan of Benefits that BlueLincs offers to you, if you do not reside in the BlueLincs Service Area, BlueLincs may facilitate your right to apply for and obtain such replacement coverage, subject to applicable eligibility requirements, from the Host Blue in which you reside. To do this we may (1) communicate directly with you and/or (2) provide the Host Blue whose service area covers the geographic area in which you reside, with your personal information and may also provide other general information relating to your coverage under the Agreement the Employer has with BlueLincs to the extent reasonably necessary to enable the relevant Host Blue to offer you coverage continuity through replacement coverage.

AGENCY RELATIONSHIPS

The Group is your agent, not our agent.

Providers are not employees, agents or other legal representatives of BlueLincs.

BLUELINCS/ASSOCIATION RELATIONSHIP

Each Member hereby expressly acknowledges his/her understanding that the Agreement constitutes a contract solely between the Group and BlueLincs. BlueLincs is a subsidiary of Health Care Service Corporation, a Mutual Legal Reserve Company, an independent licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"). The license from the Association permits BlueLincs to use the Blue Cross and Blue Shield Service Marks in the state of Oklahoma. BlueLincs is not contracting as the agent of the Association. It is further understood that the Group, on behalf of itself and each of its Members, has not entered into the Agreement based upon representations by any person other than BlueLincs and that no person, entity or organization other than BlueLincs shall be held accountable or liable to the Group or its Members for any of BlueLincs' obligations to the Group or Members created under the Agreement. This paragraph shall not create any additional

obligations whatsoever on the part of BlueLincs other than those obligations created under other provisions of the Agreement.

QUALITY IMPROVEMENT

BlueLincs has a Quality Improvement Program in place to ensure continuous improvements in the quality of clinical care and the quality of service offered to its Members. BlueLincs annually makes information about the Quality Improvement Program and a report on BlueLincs' progress available. You may request this information by contacting Customer Service at the number shown on your Identification Card.

MEDICAL TECHNOLOGY EVALUATION

BlueLincs evaluates new medical technology for possible inclusion as a covered benefit through its review of published medical research literature, comprehensive analyses of the technology's safety, efficacy and comparability to alternative technologies. The evaluation process does not require BlueLincs to change or amend the Benefits, exclusions or limitations of coverage under the Member Handbook, ***Schedule of Benefits*** or Agreement.

VALUE-BASED DESIGN PROGRAMS

BlueLincs has the right to offer health and behavior wellness, incentives, maintenance, or improvement programs that allow for a reward, a contribution, a differential in premiums or in medical, Prescription Drug or equipment Copayments, Coinsurance, Deductibles or costs, or a combination of these incentives for participation in any such program offered or administered by BlueLincs or an entity chosen by BlueLincs to administer such program. In addition, discount or incentive programs for various health or wellness-related, insurance-related or other items and services may be available from time to time. Such programs may be discontinued without notice.

Individuals unable to participate in these incentives or disincentives due to an adverse health factor shall not be penalized based upon an adverse health status and, unless otherwise permitted by law, BlueLincs will allow a reasonable alternative to any individual for whom it is unreasonably difficult, due to a medical condition, to satisfy otherwise applicable wellness program standards.

Contact BlueLincs for additional information regarding any Value-Based Programs available to you.

IDENTITY THEFT PROTECTION SERVICES

As a Member, BlueLincs makes available at no additional cost to you identity theft protection services, including credit monitoring, fraud detection, credit/identity repair to help protect your information. These identity theft protection services are currently provided by BlueLincs' designated outside vendor and acceptance or declination of these services is optional to you. Members 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 Member. Services may change or be discontinued at any time with or without notice and BlueLincs does not guarantee that a particular vendor or service will be available at any given time.

COORDINATION OF BENEFITS

When a Member or a Dependent has health coverage with more than one health plan, there will be times when the two health plans will need to coordinate benefit coverage to decide who is responsible for payment to Providers. This is called coordination of benefits (COB).

Please note that this section only applies if the Member or Dependent has health coverage under more than one plan.

Definitions

In addition to the ***Definitions*** listed in the back of this Member Handbook, the following apply to this COB provision:

- "**Other Agreement**" means any arrangement providing health care benefits or services through:
  - Group, group-type, non-group, individual, blanket or franchise insurance coverage;
  - Blue Cross, Blue Shield, Health Maintenance Organization and other prepayment coverage;
  - Coverage under labor-management trusteed plans, union welfare plans, Employer organizations plans or employee benefit organizations plans;
  - Coverage toward the cost of which any Employer has contributed, or with respect to which any Employer has made payroll deductions;
  - 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 Agreement" 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 Other Agreement covering the person for whom the claim is made or service provided.
- **"Dependent"** additionally means a person who qualifies as a Dependent under an Other Agreement.
- **"Primary Plan"** means the coverage that pays benefits or provides services first under the Order of Benefit Determination Rules below.
- **"Secondary Plan"** means any other coverage that is not a Primary Plan.

All Benefits provided under the Agreement are subject to this COB provision.

It is the responsibility of each Member to advise BlueLincs of his or her participation in any Other Agreement. We will occasionally request information from you regarding duplicate health coverage. This information is also requested on the BlueLincs application. Please complete and return the requested information promptly to ensure timely processing of your claims.

BlueLincs follows the COB rules established by state law, including the rules for determining the order in which Benefits are to be paid on behalf of Dependent children. Therefore, our Members do not have the option of choosing which plan they wish to have pay benefits first.

All Covered Services (except where Medicare is primary) must obtain Prior Authorization by your PCP and/or BlueLincs in accordance with the provisions of this Member Handbook and any Schedule(s) of Benefits.

Medicare

When Medicare is the primary payer, you may seek services from any Participating Medicare Provider.

Your Plan provides primary coverage for the following covered Medicare-eligible individuals:

- Active Employees and their spouses or Domestic Partners**, unless coverage is through an Employer with 20 Employees or less**;
- Members who are on renal dialysis for 30 months or less; and

- Members who are under 65 and who are eligible for Medicare by reason of disability.

For all other Medicare beneficiaries, Medicare is the primary carrier.

While primary medical coverage is being provided under this Plan, you may wish to enroll in Medicare, as expenses not reimbursed under this Plan may be reimbursed under Medicare. Be sure to apply for Medicare Part A (Hospital Insurance) and Part B (supplemental medical insurance) at least three months before your 65th birthday.

When Medicare provides primary coverage, this Plan will reduce Benefits payable for Covered Services by any benefits payable for the same Covered Services under Medicare.

When BlueLincs pays its Benefits **secondary** to Medicare, Members should always submit the Medicare "explanation of benefits" (EOB) form along with any statements of services rendered when filing claims for **secondary** benefits with BlueLincs.

ORDER OF BENEFIT DETERMINATION RULES

When BlueLincs is the **Primary Plan**, BlueLincs will determine the Benefits payable without regard to any Other Agreement.

When BlueLincs is the **Secondary Plan**, the Benefits BlueLincs pays for Covered Services may be reduced and will not exceed the balance of charges remaining after the benefits of Other Agreements are applied to Covered Services.

Always submit claims to the Primary Plan first. When filing a claim for secondary benefits with BlueLincs, be sure to send a copy of your EOB form from the **Primary Plan**, along with itemized statements of services rendered for which the claim is made. **Your claim cannot be processed without the EOB and itemized statements.**

In coordinating benefits, the following rules determine the order of benefits:

- When a person who received care is covered as an Employee under one plan, and as a Dependent under another, then the Employee coverage pays first.
- When a Dependent child is covered under two plans, the plan covering the child as a Dependent of the parent whose birthday falls earliest in the Calendar Year pays first. (If one plan does not follow the "birthday rule" provision, then the rule followed by that plan is used to determine the order of benefits.) However, when the Dependent child's parents are separated or divorced, the following rules apply:
  - If the parent with custody of the child has not remarried, the coverage of the parent with custody pays first.
  - When a divorced parent with custody has remarried, the coverage of the parent with custody pays first and the stepparent's coverage pays second before the coverage of the parent who does not have custody.
  - Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses, the coverage of that parent pays first.

  When none of the above circumstances applies, the coverage the person has had for the longest time pays first. The only exception is a plan that covers an individual as a laid-off or retired Employee or as a Dependent of such person pays after a plan which covers that individual as other than a laid-off or retired Employee or Dependent of such person.

In order to make this Coordination of Benefits provision work properly:

- Upon request, the Member is required to furnish BlueLincs with complete information concerning all Other Agreements that cover the person for whom the claim is made. If such information is not furnished after a reasonable time, BlueLincs shall:
  - assume the Other Agreement is required to determine its benefits first;
  - assume the benefits of the Other Agreement are identical to the benefits of this coverage.

  Once BlueLincs receives the necessary information to determine your Benefits under the Other Agreement and to establish the order of benefit determination under the rules listed above, prior payments under this coverage will be adjusted accordingly (if the above rules require it).
- If the other plan reduces your benefits because of payments you received under this coverage and the above rules do not allow such reduction, then BlueLincs will advance the remainder of your full Benefits under this coverage as if your Benefits had been determined in absence of an Other Agreement. However, BlueLincs shall be subrogated to all of your rights under the Other Agreement. You must furnish all information reasonably required by BlueLincs in such event, and you must cooperate and assist BlueLincs in recovery of such sums from the other plan.
- If the other carrier later provides benefits to you for which BlueLincs has made payments or advances under this COB provision, you must hold all such payments in trust for BlueLincs and must pay such amount to BlueLincs upon receipt.
- If payments that should have been made by BlueLincs under this Plan have been made under any other plans, BlueLincs will make the appropriate primary payments to the Provider. It will be the responsibility of the other plan to request reimbursement from the Provider for any overpayment.
- If BlueLincs has paid Benefits that result in payment in excess of the amount necessary to make this provision work properly, BlueLincs has the right to recover such excess payment from any person, any insurance company or another organization to or for, or with respect to whom such payments were made. You agree to do whatever is necessary to secure BlueLincs' right to recover the excess payment.

RIGHT OF RECOUPMENT

You agree to reimburse BlueLincs for Benefits it has paid and for which you were not eligible under the terms of the Agreement. This payment is due and payable immediately upon notification by BlueLincs. Also, BlueLincs has the sole right to determine that any overpayments, wrong payments or any excess payments made under the Agreement are an indebtedness which may be recovered by BlueLincs by deducting it from any future Benefits to which you may be entitled under the Agreement, or under any other coverage provided to you by BlueLincs. BlueLincs' acceptance of premiums or payment of Benefits under the Agreement does not waive its rights to enforce these provisions in the future.

- **BlueLincs' Right of Recoupment for Overpayments**

  If BlueLincs 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"), BlueLincs 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 not limited to, Participating Providers or out-of-network Providers.

  If no refund is received, BlueLincs (in its capacity as an insurer or administrator) 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 Agreement, whether for the same or a different Member; or

- any future benefit payment made to any person or entity under another BlueLincs-administered group self-funded benefit program and/or BlueLincs-administered insured benefit program or policy; or
- any future benefit payment made to any person or entity under another BlueLincs-insured group benefit plan or individual policy; 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.

Further, BlueLincs has the right to reduce your benefit plan's or policy's payment to a Provider by the amount necessary to recover another BlueLincs' plan's or policy's Overpayment to the same Provider and to remit the recovered amount to the other plan or policy.

- **BlueLincs' Right of Recoupment for Third Party Proceeds**

  To the extent BlueLincs 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, you agree that BlueLincs shall have a first lien on any settlement proceeds, and you shall reimburse and pay BlueLincs, on a first-priority basis, from any money recovered by suit, settlement, judgment or otherwise from any third party or his or her insurer or from any carrier providing uninsured/underinsured motorist coverage. You shall reimburse BlueLincs on a first-priority basis regardless of whether a lawsuit is actually filed or not and, if settled, regardless of how the settlement is structured or which items of damages are included in the settlement, and regardless of whether or not he or she is made whole or is fully compensated for any injuries.

  You are required to hold in trust for BlueLincs any money (up to the amount of Benefits paid by BlueLincs) recovered as described above. You are required to cooperate and furnish information and assistance which BlueLincs may require to obtain this reimbursement, including signing legal documents.

  BlueLincs HMO expressly disclaims all make whole and common fund rules and doctrines and any other rule or doctrine that would impair or interfere with BlueLincs HMO's rights herein.

LIMITATIONS ON PLAN'S RIGHT OF RECOUPMENT/RECOVERY

BlueLincs will not seek recovery of all or a portion of a payment of a claim made to a Member more than twelve (12) months or a Provider more than eighteen (18) months after the payment is made. This paragraph shall not apply:

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

WORK-RELATED ILLNESS OR INJURY

BlueLincs will not exclude coverage for any injury or illness occurring in the course of employment for which whole or partial compensation or benefits are or might be available under the laws of any government unit, any policy of workers' compensation insurance; an employer's insured and/or self-funded workers' compensation or any other plan providing coverage for work-related illness or injury; or according to any recognized legal remedy arising from an Employer-Employee relationship.

- However, BlueLincs and the Member agree that the Member will:
  - pursue his or her rights under the worker's compensation laws; and

- take no action prejudicing the right and interests of BlueLincs; and
- cooperate and furnish such information and assistance BlueLincs requires to facilitate enforcement of its rights.

- If the Member receives any money in settlement of an Employer's liability, regardless of whether the settlement includes a provision for payment of his/her medical bills, the Member agrees to hold in trust said money for the benefit of BlueLincs and to repay BlueLincs any money recovered from the Employer or insurance carrier to the extent that BlueLincs has paid any Benefits or would be obligated to pay any Benefits.

BLUELINCS HMO'S SEPARATE FINANCIAL ARRANGEMENTS WITH PRESCRIPTION DRUG PROVIDERS

BlueLincs hereby informs you that it has contracts, either directly or indirectly, with Participating Prescription Drug Providers for the provision of, and payment for, Prescription Drug services to all persons entitled to ***Prescription Drug Benefits*** under individual certificates, Group health insurance policies and contracts to BlueLincs is a party, including this Handbook, and that pursuant to BlueLincs' contracts with Participating Prescription Drug Providers, under certain circumstances described therein, BlueLincs may receive discounts for Prescription Drugs dispensed to you. Actual discounts used to calculate your share of the cost of Prescription Drugs will vary. Some discounts are currently based on Average Wholesale Price ("AWP") which is determined by a third party and is subject to change.

You understand that BlueLincs may receive such discounts. You are not entitled to receive any portion of any such discounts. The drug fees/discounts that BlueLincs has negotiated with Prime Therapeutics LLC ("Prime") through the Pharmacy Benefit Management ("PBM") Agreement, will be used to calculate your share of the cost of Prescription Drugs for both retail and mail/specialty drugs. Except for mail/specialty drugs, the PBM Agreement requires that the fees/discounts that Prime has negotiated with pharmacies (or other suppliers) are passed through to BlueLincs (and ultimately to you as described above).

For the mail pharmacy and specialty pharmacy program owned by Prime, Prime retains the difference between its acquisition cost and the negotiated prices as its fee for the various administrative services provided as part of the mail pharmacy and/or specialty pharmacy program. BlueLincs pays a fee to Prime for pharmacy benefit services. A portion of Prime's PBM fees are tied to certain performance standards, including, but not limited to, claims processing, customer service response, and mail-order processing.

"Weighted paid claim" refers to the methodology of counting claims for purposes of determining BlueLincs' fee payment to Prime. Each retail (including claims dispensed through PBM's specialty pharmacy program) paid claim will be weighted according to the days' supply dispensed. A paid claim is weighted in 34-day supply increments so a 1 – 34 days' supply is considered 1 weighted claim, a 35 – 68 days' supply is considered 2 weighted claims and the pattern continues up to 6 weighted claims for 171 or more days' supply. BlueLincs pays Prime a Program Management Fee ("PMF") on a per weighted claim days' supply.

The amounts received by Prime from BlueLincs, Pharmacies, manufacturers or other third parties may be revised from time to time. Some of the amounts received by Prime may be charged each time a claim is processed (or, in some instances, requested to be processed) through Prime and/or each time a prescription is filled, and include, but are not limited to, administrative fees charged by Prime to BlueLincs (as described above), administrative fees charged by Prime to pharmacies, and administrative fees charged by Prime to pharmaceutical manufacturers. Currently, none of these fees will be passed on to you as expenses, or accrue to the benefit of you, unless otherwise specifically set forth in this Handbook. Additional information about these types of fees or the amount of these fees is available upon request. The maximum that Prime will receive from any pharmaceutical manufacturer for certain administrative fees will be 5.5% of the total sales

for all rebatable products of such manufacturer dispensed during any given Calendar Year to Members of BlueLincs and other Blue Plan operating divisions.

BLUELINCS HMO'S SEPARATE FINANCIAL ARRANGEMENTS WITH PHARMACY BENEFIT MANAGERS

BlueLincs hereby informs you that it owns a significant portion of the equity of Prime and that BlueLincs has entered into one or more agreements with Prime or other entities (collectively referred to as "Pharmacy Benefit Managers"), for the provision of, and payment for, ***Prescription Drug Benefits*** to all persons entitled to ***Prescription Drug Benefits*** under individual certificates, Group health insurance policies and contracts to which BlueLincs is a party, including this Handbook. Pharmacy Benefit Managers have agreements with pharmaceutical manufacturers to receive rebates for using their products. In addition, Prime's mail order pharmacy and other PBM services operate through the same entity, Prime Therapeutics LLC.

Prime negotiates rebate contracts with pharmaceutical manufacturers on behalf of BlueLincs but does not retain any rebates (although Prime may retain any interest or late fees earned on rebates received from manufacturers to cover the administrative costs of processing late payments). BlueLincs may receive such rebates from Prime. You are not entitled to receive any portion of any such rebates as they are calculated into the pricing of the product.

Rights and Responsibilities

BlueLincs is happy to be able to serve you and provide the quality health care Benefits you need and deserve. As with any health insurance plan, you, and each of your covered Dependents, have certain rights and responsibilities.

1. A right to receive information about the organization, its services, its practitioners and Providers and Member rights and responsibilities.

2. A right to be treated with respect and recognition of their dignity and their right to privacy.

3. A right to participate with practitioners in making decisions about their health care.

4. A right to a candid discussion of appropriate or Medically Necessary treatment options for their conditions, regardless of cost or Benefit coverage.

5. A right to voice complaints or appeals about the organization or the care it provides.

6. A right to make recommendations regarding the organization's Member rights and responsibilities policy.

7. A responsibility to supply information (to the extent possible) that the organization and its practitioners and Providers need in order to provide care.

8. A responsibility to follow plans and instructions for care that they have agreed to with their practitioners.

9. A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

Methods of Payment and Claim Filing

FOR CARE AUTHORIZED BY YOUR PCP

BlueLincs Members receive prepaid services from the first day of coverage with only minimal Copayment, Coinsurance and/or Deductible amounts required for certain specified Covered Services. Therefore, in general, you will have no responsibility for filing of claims. Network Providers are paid directly by BlueLincs, except for your Copayment, Coinsurance and/or Deductible amounts and expenses for non-covered services.

FOR COVERED EMERGENCY CARE OR URGENT CARE SERVICES

In most cases, BlueLincs will reimburse the Hospital, Physician or other Provider for the covered Emergency Care or Urgent Care services you have received. However, it may be necessary for you to file a claim with BlueLincs in order for these Providers to receive payment. A complete written statement of services rendered should be submitted with the Provider's bill. Please make sure that you receive such a statement from the Physician or other Provider, or Hospital. If a claims payment is made directly to you, **you** are responsible for paying the Provider of services.

In some instances, payment may be required at the time of service. If this occurs, please submit an itemized bill to BlueLincs for reimbursement.

IF YOU RECEIVE A BILL

You may receive bills while you are a Member of BlueLincs. If you receive a bill in error, for authorized Covered Services, or if you must file a claim yourself (for covered Emergency Care or Urgent Care services), you may call Customer Service at the number shown on your Identification Card, or send to:

BlueLincs HMO
Customer Service Department
PO Box 655924
Dallas, TX 75265-5924

Please make copies of the itemized bills for your file before mailing them to BlueLincs.

NOTICE AND PROPERLY FILED CLAIM

Your Properly Filed Claim must be furnished to BlueLincs within 90 days after the end of the Benefit Period for which the claim is made. Failure to provide a Properly Filed Claim to BlueLincs within 90 days will not reduce any Benefit if you show that the claim was given as soon as reasonably possible.

BENEFIT DETERMINATIONS FOR PROPERLY FILED CLAIMS

Once BlueLincs receives a Properly Filed Claim from you or your Provider, a Benefit determination will be made in accordance with applicable state and federal law.

Upon receipt of your claim, if BlueLincs determines that additional information is necessary in order for your claim to be a Properly Filed Claim, we will provide written notice to you and/or your Provider, in accordance with state and federal law.

In some instances, your Medical Group may be receiving the claim and making the Benefit determinations on behalf of BlueLincs.

The procedure for appealing an Adverse Benefit Determination, whether made by BlueLincs or your Medical Group, is set forth in the section entitled ***Member Complaints and Appeals***.

DIRECT CLAIMS LINE

We have 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.

Member Complaints and Appeals

BlueLincs has established the following process to review Member 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 BlueLincs Customer Service Representative at the number on your Identification Card. 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 the BlueLincs appeal process described below.

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

CLAIM DETERMINATIONS

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

You have the right to seek and obtain a full and fair review by BlueLincs of any determination of a claim, any determination of a request for Prior Authorization, or any other determination of your Benefits made by BlueLincs under the Agreement and Member Handbook.

IF A CLAIM IS DENIED OR NOT PAID IN FULL

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

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

- The reasons for the determination;
- A reference to the Benefit provisions on which the determination is based, or the contractual or administrative basis or protocol for the determination;
- A description of additional information which may be necessary to perfect the claim and an explanation of why such material is necessary;
- Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care Provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
- An explanation of our internal review/appeals and external review processes (and how to initiate a review/appeal or external review);
- In certain situations, a statement in non-English language(s) that the written notice of the claim denial and certain other Benefit information may be available (upon request) in such non-English language(s);

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

TIMING OF REQUIRED NOTICES AND EXTENSIONS

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

- **"Urgent Care Claim"** is any pre-service request for Benefit(s) that requires Prior Authorization, as described in this Member Handbook, for Benefits for Medical Care or treatment with respect to which the application of regular time periods for making health claim decisions could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a Physician or Other Professional Provider with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment.
- **"Pre-Service Claim"** is any non-urgent request for Benefits or a determination with respect to which the terms of the Benefit plan condition receipt of the Benefit on approval of the Benefit in advance of obtaining Medical Care.
- **"Post-Service Claim" (also known as "claim")** is any request for a Benefit that is not a "pre-service" claim, and whereby notification that a service has been rendered or furnished to you is submitted to BlueLincs in an acceptable form. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the claim charge, and any other information which we may request in connection with services rendered to you.

URGENT CARE CLAIMS*

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

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

PRE-SERVICE CLAIMS

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

POST-SERVICE CLAIMS

Type of Notice or Extension	Timing
If your claim is incomplete, we must notify you within:	**30 days**
If you are notified that your claim is incomplete, you must then provide completed claim information to us within:	**45 days** after receiving notice
We must notify you of any adverse claim determination:	
if the initial claim is complete, within:	**30 days**
after receiving the completed claim (if the initial claim is incomplete), within:	**45 days**

CLAIM APPEAL PROCEDURES

- ***Claim Appeal Procedures – Definitions***

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

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

- ***Urgent Care/Expedited Clinical Appeals***

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

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

- ***How to Appeal an Adverse Benefit Determination***

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

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

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

  – Within 180 days after you receive notice of an Adverse Benefit Determination, you may call or write to our Administrative Office. We will need to know the reasons why you do not agree with

the Adverse Benefit Determination. Send your request to:

Appeal Coordinator – Customer Service Department
BlueLincs HMO
PO Box 655924
Dallas, TX 75265-5924

- We will honor telephone requests for information. However, such inquiries will not constitute a request for review.
- In support of your claim review, you have the option of presenting evidence and testimony to us. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of an Adverse Benefit Determination or at any time during the claim review process.

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

- ***Timing of Appeal Determinations***

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

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

- ***Notice of Appeal Determination***

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

  The written notice to you or your authorized representative will include:

  - A reason for the determination;
  - A reference to the Benefit plan provisions on which the determination is based, and the contractual or administrative basis or protocol for the determination;
  - Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care Provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;

- An explanation of our external review processes (and how to initiate an external review);
- In certain situations, a statement in non-English language(s) that the written notice of the claim denial and certain other Benefit information may be available (upon request) in such non-English language(s);
- In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by us;
- The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for Benefits;
- Any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
- An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;
- A description of the standard that was used in denying the claim and a discussion of the decision; and
- Contact information for applicable office of health insurance consumer assistance or ombudsman.

EXTERNAL REVIEW RIGHTS

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

You or your authorized representative may file a request for a standard or expedited external review by completing the required forms and submitting them directly to the address noted below. We will also provide the forms to you upon request.

Oklahoma Insurance Department
PO Box 53408
Oklahoma City, OK 73152-3408
Telephone: 1-800-522-0071 (Oklahoma only) or 405-521-2828

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

For questions or assistance regarding the right to an external review by an independent review organization, the Member may call Customer Service at the number found on the back of their Identification Card.

Members may also contact the Oklahoma Insurance Department at the following address:

Oklahoma Insurance Department
400 NE 50th Street
Oklahoma City, OK 73105
Telephone: 1-800-522-0071 or 405-521-2828
www.oid.ok.gov/consumers/external-review-process

Your ERISA Rights

As a participant in this Plan, you may be entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). Check with your Group Administrator to see if your Plan is governed by ERISA.

ERISA RIGHTS

If your claim for Benefits is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator (your Employer) to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for Benefits, which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the Pension and Welfare Benefits Administration.

Definitions

This section defines terms that have special meanings in this Member Handbook. 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.

AGREEMENT

The Group Administration Document issued to the Employer by BlueLincs. This Member Handbook contains the principal provisions of the Group Administration Document, ***Schedule of Benefits*** and any attachments and/or riders.

AGREEMENT ANNIVERSARY DATE

The date the Agreement renews and each 12-consecutive-month renewal date thereafter.

AGREEMENT EFFECTIVE DATE

The date the Agreement between the Employer and BlueLincs begins.

ALLOWABLE CHARGE

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

- ***For Comprehensive Health Care Services:***
  - **BlueLincs Participating Provider –** the Provider's usual charge, not to exceed the amount the Provider has agreed to accept as payment for Covered Services in accordance with a BlueLincs Provider Agreement.
  - **Non-Participating (Non-Contracting) Providers** – the lesser of: (a) the Provider's billed charge; or (b) BlueLincs' Non-Contracting Allowable Charge as set forth in the "***General Provisions***" section.
- ***For Outpatient Prescription Drugs and Related Services:***
  - **Participating Pharmacy** – the Pharmacy's usual charge, not to exceed the amount the Pharmacy has agreed to accept as payment for Covered Services in accordance with a Participating Pharmacy Agreement.
  - **Non-Participating Pharmacy** – the Pharmacy's usual charge, not to exceed the amount that BlueLincs would reimburse a Participating Pharmacy for the same service.

Please refer to "Out-of-Area Services" in the *General Provisions* section for information regarding Covered Services received from non-Participating Providers outside the BlueLincs Service Area.

AMBULATORY SURGICAL FACILITY

A Provider with an organized staff of Physicians or Other Professional Providers which:

- Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
- Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;

- Does not provide Inpatient accommodations; and
- Is not, other than incidentally, a facility used as an office or clinic for the private practice of a Physician or other Provider.

ANNUAL TRANSFER PERIOD

The 31-day period immediately before the Group's Agreement Anniversary Date, or other period mutually agreed to between the Group and BlueLincs, during which an Eligible Person who has coverage through the Employer's alternate health plan can apply to transfer the coverage to the Agreement.

APPLIED BEHAVIOR ANALYSIS

The design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce social significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

AUTISM SPECTRUM DISORDER

Any of the pervasive developmental disorders or autism spectrum disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the edition that was in effect at the time of diagnosis.

BENEFIT PERIOD

The specified period of time during which charges for Covered Services must be incurred in order to be eligible for payment by BlueLincs. A charge shall be considered incurred on the date the service or supply was provided to a Member. Benefit Period shall mean a Calendar Year.

BENEFITS

The payment, reimbursement and indemnification of any kind which you will receive from and through BlueLincs under this Member Handbook.

BIOMARKER TESTING

The analysis of tissue, blood, or other biospecimen for the presence of a biomarker, including single-analyte tests, multiplex panel tests, gene or protein expression, and whole exome, whole genome, and whole transcriptome sequencing.

BLUECARD® PROGRAM

A program which offers access to out-of-town care through Participating Blue Cross and Blue Shield HMOs located across the country.

BRAND NAME DRUG (NON-PREFERRED)

A brand-name Prescription Drug which appears on the applicable Drug List and is identified as a Non-Preferred Brand Drug. The Drug List is available on the Plan's website at www.bcbsok.com.

BRAND NAME DRUG (PREFERRED)

A brand-name drug which appears on the applicable Drug List and is identified as a Preferred Brand Drug. The Drug List is available on the Plan's website at www.bcbsok.com.

CALENDAR YEAR

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

CARE COORDINATION

Organized, information-driven patient care activities intended to facilitate the appropriate responses to Member's health care needs across the continuum of care.

CARE COORDINATOR FEE

A fixed amount paid by BlueLincs or a Blue Cross and/or Blue Shield Plan to Providers periodically for Care Coordination under a Value-Based Program.

COBRA CONTINUATION COVERAGE

Coverage under a Group Health Plan that satisfies the provisions of COBRA (Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended).

COINSURANCE

The *percentage* of Allowable Charges for Covered Services for which the Member is responsible.

COPAYMENT

A fixed dollar amount required to be paid by or on behalf of a Member in connection with the delivery of some Covered Services. Refer to the ***Schedule of Benefits*** for any Copayments applicable to your coverage.

COVERED DRUG

Any Prescription Drug, injectable drug, or self-injectable drug including insulin, disposable syringes and needles needed for self-administration:

- Which is included on the applicable Drug List;
- Which is Medically Necessary and is ordered by a Provider naming a Member as the recipient;
- For which a written or verbal Prescription Order is prepared by a Provider;
- For which a separate charge is customarily made;
- Which is not consumed at the time and place that the Prescription Order is written;
- For which the Food and Drug Administration (FDA) has given approval for at least one indication; and
- Which is dispensed by a Pharmacy and is received by the Member while covered under this Member Handbook, except when received from a Provider's office, or during confinement while a patient is in a Hospital or other acute care institution or facility.

As new drugs are approved by the Food and Drug Administration (FDA), such drugs, unless the intended use is specifically excluded under the Member Handbook, will be reviewed by BlueLincs and may be added to the applicable Drug List and be eligible for Benefits as outlined in the ***Schedule of Benefits for Outpatient Prescription Drugs and Related Services***.

COVERED SERVICE

A service or supply a Member receives from a Provider and for which BlueLincs will provide Benefits according to the Agreement and Member Handbook.

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 dollar amount of Covered Services that a Member 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

Any person in a Subscriber's family who meets the eligibility requirements of the Agreement.

DOMESTIC PARTNER

A companion of the same sex or opposite sex with whom the Subscriber has entered into a Domestic Partnership in accordance with the Employer's guidelines. All provisions of this Member Handbook (with the exception of COBRA Continuation Coverage), that pertain to a spouse also pertain to a Domestic Partner once eligibility is determined. Check with your Group Administrator for Domestic Partner provisions unique to your Group's coverage.

NOTE: A Domestic Partner is not recognized as a spouse for certain federally regulated programs, such as COBRA Continuation Coverage and Medicare.

DOMESTIC PARTNERSHIP

A same-sex or opposite-sex couple in a committed relationship, similar to a marriage, but without an official marriage license.

DRUG LIST

A list of drugs that may be covered under the ***Outpatient Prescription Drugs and Related Services*** section of this Member Handbook. The Drug List is subject to periodic review and may change at any time by BlueLincs. A current list is available on our website at www.bcbsok.com. You may also contact a Customer Service Representative at the telephone number shown on the back of your Identification Card for more information.

DURABLE MEDICAL EQUIPMENT

Equipment which meets the following criteria:

- It is used in the Member's home, place of residence or dwelling;
- It provides therapeutic benefits or enables the Member 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
- It is prescribed by a Physician or Other Professional Provider and meets the BlueLincs's criteria of Medical Necessity for the given diagnosis.

EFFECTIVE DATE

The date when a Member's coverage begins.

ELIGIBLE PERSON

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

EMERGENCY CARE

Treatment in a Hospital emergency department (emergency room) or other comparable facility 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 Member's health (or, with respect to a pregnant woman, the health of the woman or her unborn child;
- serious impairment to bodily function; or
- serious dysfunction of any bodily organ or part; or
- with respect to a pregnant woman who is having contractions:
  - there is inadequate time to effect a safe transfer to another Hospital before delivery; or
  - transfer may pose a threat to the health or safety of the woman or the unborn child.

EMPLOYEE

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

EMPLOYER

A Group, as defined, in which there exists an employment relationship between a Subscriber and the Group.

EXPERIMENTAL, INVESTIGATIONAL AND/OR UNPROVEN

A drug, device, biological product, or medical treatment or procedure is Experimental, Investigational or Unproven if **BlueLincs 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 the 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.

Approval by a governmental or regulatory agency will be taken into consideration by BlueLincs in assessing Experimental, Investigational and/or Unproven status of a drug, device, biological product, or medical treatment or procedure but will not be determinative.

FAMILY COVERAGE

Coverage for the Subscriber and one or more of the Subscriber's Dependents.

GENERIC DRUG

A drug that has the same active ingredient as a brand-name drug and is allowed to be produced after the brand-name drug's patent has expired. To determine which drugs are Preferred Generic Drugs or Non-Preferred Generic Drugs, refer to the Drug List on the Plan's website at www.bcbsok.com. You may also contact a Customer Service Representative at the number shown on your Identification Card for more information. All products identified as a Generic Drug by the drug product database, manufacturer, Pharmacy, or your Physician or other Provider may not be considered a Generic Drug by the Plan.

GENERIC DRUG (NON-PREFERRED)

A Generic Drug which appears on the applicable Drug List and is identified as a Non-Preferred Generic Drug. The Drug List is available on the Plan's website at www.bcbsok.com.

GENERIC DRUG (PREFERRED)

A Generic Drug which appears on the applicable Drug List and is identified as a Preferred Generic Drug. The Drug List is available on the Plan's website at www.bcbsok.com.

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 to acquire BlueLincs 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.

HEALTH MAINTENANCE ORGANIZATION (HMO)

An organized system of health care that provides a comprehensive package of health services, through Participating Providers, to a voluntarily enrolled membership, within a particular geographic area.

HOME HEALTH CARE AGENCY

An organization certified as a Home Health Care Agency under Medicare, or otherwise approved by BlueLincs for the delivery of non-Physician patient care in the home of a Member.

HOME HEALTH CARE SERVICES

Services provided by a Home Health Care Agency on a part-time, intermittent basis when a Member is confined to his or her home because of disease or injury.

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 facility licensed as a Hospital as required by law, which is primarily engaged in providing diagnostic and therapeutic facilities for the treatment and care of injured and sick persons, by or under the supervision of a staff of Physicians who are duly licensed to practice medicine and Surgery, and which continuously provides 24-hour a day nursing services.

HOSPITAL ADMISSION

The period from your entry (admission) into a Hospital for Inpatient treatment until your discharge.

HOSPITAL SERVICES

Services for registered bed patients or Outpatients.

IATROGENIC INFERTILITY

An impairment of fertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment with a potential side effect of impaired fertility as established by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.

INFUSION SUITE

An alternative to Hospital and clinic-based infusion settings where specialty medications can be infused.

INITIAL ENROLLMENT PERIOD

The 31-day period immediately following the date an Employee or Dependent first becomes eligible to enroll for coverage under the Agreement.

INPATIENT

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

LIFE-THREATENING DISEASE OR CONDITION

For the purposes of a clinical trial, any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

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.

MEDICAL CARE

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

MEDICAL GROUP

A Medical Group which has entered into a contractual agreement with BlueLincs for the provision of services to Members on an agreed upon basis.

MEDICAL GROUP NETWORK

The group of Providers (including Physicians, Specialists, Hospitals and other professionals who provide health care services to BlueLincs Members) affiliated with the same Medical Group as the Member's PCP.

MEDICAL SERVICES

Those professional services of Physicians and paramedical personnel, including medical, surgical, diagnostic, therapeutic and preventive services.

MEDICALLY NECESSARY (OR MEDICAL NECESSITY)

Health care services that BlueLincs determines 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; and
- 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 site, 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 and amendments, as amended.

MEMBER

Any Subscriber or Dependent eligible for and enrolled for BlueLincs services.

MENTAL HEALTH AND SUBSTANCE USE DISORDER

Any condition or disorder involving a mental health condition or substance use disorder listed under any of the diagnostic categories in the mental disorders section of the most recent edition of the International Classification of Disease or in the mental disorders section of the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

OPEN ENROLLMENT PERIOD

A period mutually agreed upon between the Group and BlueLincs, immediately before the Group's Agreement Anniversary Date (renewal date), during which an individual who previously declined coverage may enroll for coverage under the Agreement.

OTHER PROFESSIONAL PROVIDER

A person other than a Physician who is a professional practitioner properly licensed, certified or authorized under applicable state law or, if no state authorization is required, by a legally constituted professional association recognized by the Plan, to engage in the delivery of health care services and who provides such services within the scope of such license or authority. Examples include Physician Assistants, Advanced Practice Registered Nurses, Licensed Professional Counselors, etc.

OUT-OF-POCKET LIMIT

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

- Member-Only (Single) Coverage – When you have satisfied the Out-of-Pocket Limit specified in the ***Schedule of Benefits for Comprehensive Health Care Services***, no additional Copayments, Coinsurance and/or Deductible will be required for Covered Services you incur during the remainder of the Benefit Period.
- Family Coverage – When any one or more covered family members have paid the Out-of-Pocket Limit specified in the ***Schedule of Benefits for Comprehensive Health Care Services***, no additional Copayments, Coinsurance and/or Deductible will be required for Covered Services incurred by any Members under the same Family Coverage 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 this Handbook.

OUTPATIENT

A Member who receives services or supplies during a visit to the Hospital which lasts less than 24 hours and who is not registered as Inpatient.

PARTICIPATING PHARMACY

An independent retail Pharmacy, chain of retail Pharmacies, mail-order Pharmacy or specialty Pharmacy that has entered into a written agreement with BlueLincs, or other entity chosen by BlueLincs to administer its Prescription Drug program, to provide pharmaceutical services to you.

To find a Pharmacy in the Participating Pharmacy Network, please refer to BlueLincs' website at www.bcbsok.com or call a Customer Service Representative at the number shown on your Identification Card.

PARTICIPATING PROVIDER

Any Physician, Specialist, Hospital, Home Health Care Agency, or other practitioner or Provider of Medical Services or supplies that has entered into a contractual agreement with BlueLincs for the provision of services to Members.

PARTICIPATING RETAIL PHARMACY

A pharmacy that has entered into an agreement to be part of the BlueLincs Pharmacy Network.

PARTICIPATING SPECIALTY PHARMACY

A pharmacy that has entered into agreement with BlueLincs to provide Specialty Drugs to BlueLincs Members.

PARTICIPATING SKILLED NURSING FACILITY

A Skilled Nursing Facility which has entered into a contractual Agreement with BlueLincs and/or a Participating Medical Group for the provision of Skilled Nursing Facility services to Members on a negotiated basis.

PHYSICIAN

A Physician, as defined under Oklahoma law, who is properly licensed to provide medical and/or surgical care under the laws of the state where the individual practices and provides 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.

POST-SERVICE MEDICAL NECESSITY REVIEW

A Post-Service Medical Necessity Review, sometimes referred to as a retrospective review or post-service claims request, is the process of determining coverage after treatment has already occurred and is based on Medical Necessity guidelines.

PREFERRED PARTICIPATING PHARMACY

A Participating Pharmacy which has a written Agreement with Blue Cross and Blue Shield of Oklahoma to provide pharmaceutical services to Members or an entity chosen by the Plan to administer its Prescription Drug program that has been designated as a "Preferred Participating Pharmacy".

To find a Preferred Participating Pharmacy, please refer to the Plan's website at www.bcbsok.com or call a Customer Service Representative at the number shown on your Identification Card.

PRESCRIPTION DRUG

Any medicinal substance required by the Federal Food, Drug and Cosmetic Act to bear the following legend on its label: "Caution: Federal law prohibits dispensing without a prescription.".

PRESCRIPTION ORDER

A written order, and each refill, for a Prescription Drug issued by a Participating Physician or Other Professional Provider.

PREVENTIVE CARE SERVICES

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF");
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved;
- Evidenced-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") for infants, children, and adolescents; and

- With respect to women, such additional preventive care and screenings, not described above, as provided for in comprehensive guidelines supported by the HRSA, including breast-feeding support, services and supplies and contraceptive services, as set forth in the ***Comprehensive Health Care Services*** section.
- The Preventive Care Services described above may change as the USPSTF, CDC, and HRSA guidelines are modified.

PRIMARY CARE PROVIDER (PCP)

A person who is a professional practitioner of a healing art defined and recognized by law, to include family practitioner, obstetrician/gynecologist, pediatrician, internist and Physician assistant or advanced practice registered nurse who provides health care and services generally accepted within the scope of the Provider's license. A PCP is not a Specialist.

PRIOR AUTHORIZATION

The process of requiring Participating Providers or Medical Group Participating Providers to obtain authorization from a Member's PCP and/or BlueLincs prior to scheduling all non-primary care Medical Services (excluding Emergency Care).

PROPERLY FILED CLAIM

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

PROVIDER

A Physician or Other Professional Provider, Hospital, Skilled Nursing Facility, Home Health Care Agency or other Provider as determined by BlueLincs.

PROVIDER INCENTIVE

An additional amount of compensation paid to a health care Provider by BlueLincs, based on the Provider's compliance with agreed-upon procedural and/or outcome measures for a particular population of Members.

PSYCHIATRIC HOSPITAL

A Provider that is a state licensed Hospital that primarily specializes in the treatment of severe Mental Health and Substance Use Disorder.

QUALIFYING EVENT

Any one of the following events, which, but for the COBRA Continuation Coverage provisions described in this Member Handbook, would result in the loss of a Member's coverage:

- The death of the covered Employee;
- The termination (other than by reason of a covered Employee's gross misconduct), or reduction of hours, of the covered Employee's employment;
- The divorce or legal separation of the covered Employee from the Employee's spouse;
- The covered Employee becoming entitled to benefits under Medicare;

- A Dependent child ceasing to be eligible.

RECOMMENDED CLINICAL REVIEW

An optional voluntary review of a Provider's recommended medical procedure, treatment or test, that does not require Prior Authorization, to make sure it meets approved BlueLincs medical policy guidelines and Medical Necessity requirements.

RESIDENTIAL TREATMENT CENTER (RTC)

A facility setting offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a level of security, supervision, and structure Medically Necessary to meet the needs of patients served or to be served by such facility. Residential Treatment Centers must be licensed by the appropriate state and local authority as a Residential Treatment Facility or its equivalent under the laws or regulations of such locality and/or must be accredited by a national accrediting body as a Residential Treatment Center or its equivalent. Accepted accrediting bodies are The Joint Commission, Commission on Accreditation of Services for Families and Children Inc. (COA), or National Integrated Accreditation of Healthcare Organizations (NIAHOSM). This includes any specialized licensing that may be applicable given the services to be provided or population to be served.

As they do not provide the level of care, security or supervision appropriate of a Residential Treatment Center, the following shall not be included in the definition of Residential Treatment Center:

- Half-way houses;
- Supervised living;
- Group homes;
- Wilderness programs;
- Boarding houses; or
- Other facilities that provide primarily a supportive/custodial environment and/or primarily address long term social needs, even if counseling is provided in such facilities.

To qualify as a Residential Treatment Center, patients must be medically monitored with 24-hour medical professional availability and on-site nursing care and supervision for at least one shift a day with on call availability for the other shifts.

RETAIL HEALTH CLINIC

A health care clinic located in a retail setting, supermarket or Pharmacy which provides treatment of common illnesses and routine preventive health care services rendered by a Physician or other Provider.

RETAIL PHARMACY VACCINATION NETWORK

A network of Participating Pharmacies that have certified vaccination pharmacists on staff who have contracted to administer select vaccinations to Members.

ROUTINE NURSERY CARE

Ordinary Hospital nursery care of the newborn Member.

SELF-REFERRAL SERVICES

Services which are not provided or authorized in advance by the Member's PCP.

SERVICE AREA

The geographic area in which BlueLincs is licensed by the Oklahoma Insurance Department to provide health care services. A Member may call the BlueLincs Customer Service at the number shown on your Identification Card to determine if he or she is in the Service Area or log on to the website at www.bcbsok.com.

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 or Other Professional Providers. A Skilled Nursing Facility is not, other than incidentally, a place that provides:

- Custodial Care, ambulatory, or part-time care; or
- Treatment for Mental Health and Substance Use Disorder or pulmonary tuberculosis.

SPECIAL ENROLLMENT PERIOD

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

SPECIALIST

A Physician or Other Professional Provider who provides Medical Services in any generally accepted medical specialty or sub-specialty.

SPECIALTY DRUG (NON-PREFERRED)

A Specialty Drug which appears on the applicable Drug List and is identified as a Non-Preferred Specialty Drug. The Drug List is available on the Plan's website at www.bcbsok.com.

SPECIALTY DRUG (PREFERRED)

A Specialty Drug which appears on the applicable Drug List and is identified as a Preferred Specialty Drug. The Drug List is available on the Plan's website at www.bcbsok.com.

SPECIALTY PHARMACY DRUGS

Specialty medications are used to treat complex medical conditions, and are typically given by injection, but may be topical or taken by mouth. They also often require careful adherence to treatment plans, may have special handling or storage requirements, and may not be stocked by retail pharmacies. Some conditions such as hepatitis C, hemophilia, multiple sclerosis and rheumatoid arthritis are treated with Specialty Drugs. To determine which drugs are Specialty Drugs (Preferred) or Specialty Drugs (Non-Preferred), refer to the website at www.bcbsok.com or call the Customer Service toll-free number on your Identification Card.

SPECIALTY PHARMACY NETWORK

A limited network of Participating Pharmacies that provide the following services to Members:

- access to high-cost medications that are used in limited populations;
- special dispensing, delivery and patient clinical support;
- guidance through complex reimbursement procedures for Specialty Pharmacy Drugs.

STANDARD FERTILITY PRESERVATION SERVICES

Oocyte and sperm preservation procedures, including ovarian tissue, sperm, and oocyte cryopreservation, that are consistent with established medical practices or professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine; provided, however, standard fertility preservation services shall not include storage.

SUBSCRIBER

An eligible Employee of the Employer who is enrolled for coverage.

SURGERY

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

TELEMEDICINE VISITS

The diagnosis, consultation or treatment provided by a licensed Provider through one or more technology-enabled health and care management and delivery systems that extend capacity and access to care.

THERAPY SERVICE

The following services and supplies ordered by a Physician or other Provider when used to treat and promote your recovery from an illness or injury, or that are provided in order for a person to attain, maintain or prevent deterioration of a skill or function never learned or acquired due to a disabling condition:

- **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.
- **Infusion Therapy** – the administration of medication through a needle or catheter. Typically, "Infusion Therapy" means that a drug is administered intravenously, but the term also may refer to situations where drugs are provided through other non-oral routes, such as intramuscular injections and epidural routes (into the membranes surrounding the spinal cord). Infusion Therapy is prescribed when a patient's condition is so severe it cannot be treated effectively by oral medications.
- **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, to restore, attain or maintain maximum function, and to prevent disability or deterioration of a skill or function resulting from a disabling condition, 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 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.

- **Manipulative Therapy** – hands on treatment of muscles, tendons, ligaments and joint disorders by chiropractic or osteopathic manual therapy.

TOTAL DISABILITY (OR TOTALLY DISABLED)

A condition resulting from disease or injury in which, as certified by a Physician:

- A Member is unable to perform the substantial duties of any occupation or business for which he/she is qualified and the Member is not in fact engaged in any occupation for wages or profit; or
- If the Member does not usually work for wages or profit, the Member cannot do the normal activities of a similarly situated person who is not disabled.

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

URGENT CARE

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, severe vomiting and diarrhea, pulled muscles, or other similar illnesses or injuries.

VALUE-BASED PROGRAM

An outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local Providers that is evaluated against cost and quality metrics/factors and is reflected in Provider payment.

WAITING PERIOD

The period that must pass before an Eligible Person or Dependent is eligible to enroll under the terms of a Group Health Plan. If an Eligible Person or Dependent enrolls during a Special Enrollment Period, any period before such special enrollment is not a Waiting Period.

NOTICE OF
PROTECTION PROVIDED BY
OKLAHOMA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary of the Oklahoma Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Oklahoma law, which determines who and what is covered and the amounts of coverage. The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Oklahoma law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values
- Health Insurance
  - $500,000 in hospital, medical and surgical insurance benefits
  - $300,000 in disability income insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits
- Annuities
  - $300,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000, except that with regard to hospital, medical and surgical insurance benefits, the maximum amount that will be paid is $500,000.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Oklahoma law.

To learn more about the above protections, please visit the Association's website at www.oklifega.org, or contact:

Oklahoma Life & Health Insurance Guaranty Association
201 Robert S. Kerr, Suite 600
Oklahoma City, OK 73102
Phone: (405) 272-9221

Oklahoma Department of Insurance
400 NE 50th Street
Oklahoma City, OK 73105
1-800-522-0071 or (405) 521-2828

Insurance companies and agents are not allowed by Oklahoma law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Oklahoma law, then Oklahoma law will control.

NOTICE

RELIGIOUS AND MORAL EXEMPTION AND ELIGIBLE ORGANIZATION ACCOMMODATION

A certification(s) may have been provided to BlueLincs that your Group Health Plan is established or maintained by an objecting organization(s) as provided in 45 C.F.R. 147.132(a) or 45 C.F.R. 147.133(a), as modified or replaced, and qualifies for a religious or moral exemption from the Affordable Care Act requirement to cover certain contraceptive services without cost sharing under guidelines supported by the Health Resources and Services Administration ("Religious or Moral Exemption"). Provided that the Religious or Moral Exemption is satisfied for your Group Health Plan, then coverage under your Group Health Plan, as set forth under *"Preventive Care Services"* in the ***Comprehensive Health Care Services*** section of your Certificate, will not include coverage for some or all of such contraceptive services (please call Customer Service at the number on the back of your Identification Card for more information). Questions regarding the Religious or Moral Exemption should be directed to your Group Administrator.

In addition, a certification(s) may have been provided to BlueLincs that your Group Health Plan is established or maintained by an organization(s) that is an "eligible organization(s)" as defined in 45 C.F.R. 147.131(c), as modified or replaced, and qualifies for an eligible organization accommodation with respect to the Affordable Care Act requirement to cover certain contraceptive services without cost sharing under guidelines supported by the Health Resources and Services Administration ("Eligible Organization Accommodation"). Provided that the Eligible Organization Accommodation is satisfied, coverage under your Group Health Plan, as set forth under *"Preventive Care Services"* in the ***Comprehensive Health Care Services*** section of your Certificate, will not include coverage for some or all of such contraceptive services, but will be provided through BlueLincs at no cost share. If you have questions regarding the certification(s), you may contact your Group Administrator. For other questions about the Eligible Organization Accommodation, you may contact Customer Service at the number on the back of your Identification Card.

BlueLincs HMO℠

Health care coverage is important for everyone.

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984. We provide free communication aids and services for anyone with a disability or who needs language assistance.

We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability. If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator	Phone:	855-664-7270 (voicemail)
300 E. Randolph St., 35th Floor	TTY/TDD:	855-661-6965
Chicago, IL 60601	Fax:	855-661-6960

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services	Phone:	800-368-1019
200 Independence Avenue SW	TTY/TDD:	800-537-7697
Room 509F, HHH Building 1019	Complaint Portal:	https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf
Washington, DC 20201	Complaint Forms:	https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html

	To receive language or communication assistance free of charge, please call us at 855-710-6984.
Español	Llámenos al 855-710-6984 para recibir asistencia lingüística o comunicación en otros formatos sin costo.
العربية	لتلقي المساعدة اللغوية أو التواصل مجانًا، يرجى الاتصال بنا على الرقم 855-710-6984.
繁體中文	如欲獲得免費語言或溝通協助，請撥打855-710-6984與我們聯絡。
Français	Pour bénéficier gratuitement d'une assistance linguistique ou d'une aide à la communication, veuillez nous appeler au 855-710-6984.
Deutsch	Um kostenlose Sprach- oder Kommunikationshilfe zu erhalten, rufen Sie uns bitte unter 855-710-6984 an.
ગુજરાતી	ભાષા અથવા સંચાર સહાય મફતમાં મેળવવા માટે, કૃપા કરીને અમને 855-710-6984 પર કૉલ કરો.
हिंदी	निःशुल्क भाषा या संचार सहायता प्राप्त करने के लिए, कृपया हमें 855-710-6984 पर कॉल करें।
Italiano	Per assistenza gratuita alla lingua o alla comunicazione, chiami il numero 855-710-6984.
한국어	언어 또는 의사소통 지원을 무료로 받으려면 855-710-6984번으로 전화해 주세요.
Navajo	Niná: Doo bilagáana bizaad dinits'á'góó, shá ata' hodooni nínízingo, t'áájíík'eh bee náhaz'á. 1-866-560-4042 jį' hodíilnį.
فارسی	برای دریافت کمک زبانی یا ارتباطی رایگان، لطفاً با شماره 855-710-6984 تماس بگیرید.
Polski	Aby uzyskać bezpłatną pomoc językową lub komunikacyjną, prosimy o kontakt pod numerem 855-710-6984.
Русский	Чтобы бесплатно воспользоваться услугами перевода или получить помощь при общении, звоните нам по телефону 855-710-6984.
Tagalog	Para makatanggap ng tulong sa wika o komunikasyon nang walang bayad, pakitawagan kami sa 855-710-6984.
اردو	مفت میں زبان یا مواصلت کی مدد موصول کرنے کے لیے، براہ کرم ہمیں 855-710-6984 پر کال کریں۔
Tiếng Việt	Để được hỗ trợ ngôn ngữ hoặc giao tiếp miễn phí, vui lòng gọi cho chúng tôi theo số 855-710-6984.

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