

Your Health Care Benefits Program



BlueLincsSM

Sample



BlueCross BlueShield of Oklahoma

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This certificate is only a representative sample and does not constitute an actual insurance policy or contract.

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Sample

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 Master Agreement (the “Agreement”). BlueLincs HMO (also called BlueLincs, we, us or our) provides only the Benefits specified in the Agreement and the *Schedule of Benefits* 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 and Termination* section; and
- been approved by BlueLincs.

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 BLUELINC'S

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 Physician (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.

This certificate is only a representative sample and does not constitute an actual insurance policy or contract.

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.

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This certificate is only a representative sample and does not constitute an actual insurance policy or contract.

How BlueLincs Works

YOUR PRIMARY CARE PHYSICIAN (PCP)

- **Choosing Your PCP**

When you enroll, you will receive a directory of BlueLincs Providers free of charge. You will choose a PCP from the Provider Directory. Your PCP is your personal health care manager and will share with you the responsibility for your total health care.

You must choose a PCP when you enroll and include your choice on your application. 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.

When choosing your PCP, there may be information you need to know, such as an address, phone number and specialty. This information, including detailed maps to the doctor's office, can be found on our Web site at www.bcbsok.com. If you do not have Internet access, you may obtain Provider information, including a listing of BlueLincs Providers, by contacting Customer Service at the number shown on 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 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.

- **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 Physician-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 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 doctor and other patients who may need that available appointment.

BlueLincs is not responsible for any Physician 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 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 MAXIMUM

To make sure that your shared payment amounts do not become a burden, there is a maximum amount of covered expenses you are required to pay during a Benefit Period. This is called your Out-of-Pocket Maximum and the specific dollar amount will be listed in your *Schedule of Benefits*. After you reach your Out-of-Pocket Maximum 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 Maximum amount specified in the *Schedule of Benefits*.

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

- Outpatient Prescription Drugs and related services;
- 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 “*Preauthorization Request Involving Urgent Care*”, a health care professional with knowledge of your medical condition will be permitted to act as your authorized representative.

Preauthorization

Preauthorization is the process of requiring Participating Providers or Medical Group Participating Providers to obtain authorization from a Member's Primary Care Physician, and/or BlueLincs prior to scheduling all non-primary care Medical Services (excluding Emergency Care). Failure to follow this process will result in denial of Benefits. The Preauthorization process may be handled by BlueLincs, your PCP and/or your Medical Group. In any event, the process for obtaining Preauthorization is as follows:

PREAUTHORIZATION 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 five 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 additional time is necessary, you will be given written notification, prior to the expiration of the original five-day period, that the extension is necessary, along with an explanation of the circumstances requiring the extension of time and the date by which the determination will be given.

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 Preauthorization within five days following receipt of the additional information.

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

PREAUTHORIZATION REQUESTS INVOLVING URGENT CARE

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

- could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function; or
- in the opinion of a Physician 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 Preauthorization request.

In case of a "Preauthorization 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 BlueLines 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).

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Eligibility, Enrollment, Changes and 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.

If you meet this description of an Eligible Person, you are entitled to the Benefits of this program.

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.
- 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 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 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 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, 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.

- **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, 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.

DELAYED EFFECTIVE DATE

If you apply for coverage and are not Actively at Work on what would be your Effective Date, the Effective Date will be delayed until the date you are Actively at Work. This provision will not apply if you were:

- an Eligible Person who is absent from work due to a health status factor; or
- enrolled under the Employer's Group Health Plan in force immediately preceding the Agreement Effective Date; or
- covered under the Employer's Alternate Health Plan, except as may be specifically provided for in such Alternate Health Plan.

In no event will your Dependent's coverage become effective prior to your Effective Date.

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.

ALTERNATE COVERAGE OPTIONS

Some Employer Groups offer coverage through an Alternate Health Plan. Check with your Group Administrator to see what coverage options are available to you.

If your Group does offer coverage options other than this Plan, an Annual Transfer Period will be held each year during a period that has been mutually agreed upon between the Group and BlueLincs (contact the Group Administrator for specific dates). During this period, you may transfer your coverage to an Alternate Health Plan. Your Effective Date will coincide with your Group's Agreement Anniversary Date.

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.

- **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 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.

CONVERSION PRIVILEGE AFTER TERMINATION OF GROUP COVERAGE

If you stop being a Subscriber under the Agreement or you change jobs and your new Employer does not offer Group health insurance, and if you continue to reside or work in the BlueLincs Service Area, you may apply for conversion coverage by following these procedures:

- Contact BlueLincs Customer Service at the number shown on your Identification Card to request conversion information and an application form.
- Written application for a conversion contract must be received by BlueLincs no later than 31 days after the date the Subscriber's coverage terminates. Your coverage will become effective the day after your Group coverage terminates if the appropriate premium is paid and the procedures mentioned above are followed.

A conversion contract will not be available if you no longer live or work within the BlueLincs Service Area, or if your coverage is terminated due to:

- nonpayment of premium by your Employer;
- termination by BlueLincs;
- nonpayment of required Copayment, Coinsurance and/or Deductible amounts;
- commission of fraud or intentional misrepresentation of a material fact; or
- termination of the Agreement.

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

If you continue working full time, this Plan will continue to provide the same Benefits that apply to Employees under age 65. Coverage for your spouse or Domestic Partner (provided your Group covers Domestic Partners) and Dependents will also continue.

If your Group coverage ends and you are age 65 or older, contact BlueLincs for details regarding coverage options available to supplement your Medicare coverage.

NOTE: Some Groups have special eligibility provisions regarding retired Employees. Check with your Group Administrator for retiree eligibility provisions unique to your Group's coverage.

IMPORTANT: You are eligible for Medicare on the first day of the month you become age 65. You should apply for Medicare at least three months before your birthday.

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 Preauthorization was received from BlueLincs, after a Member's coverage under this Plan is terminated.

Sample

Types of Covered Care

ROUTINE CARE

When you need routine care, contact your PCP's office for an appointment. Show your Identification Card and pay any Copayment, Coinsurance and/or Deductible amount at the time of the visit. Routine care (such as periodic physicals and childhood immunizations) is not covered when Members are outside the BlueLincs Service Area. Routine care includes, but is not limited to the following preventive care services:

- Newborn and well child care;
- Periodic physical exams;
- Childhood immunizations (as recommended by the Centers for Disease Control);
- Vision and hearing screening to age 19;
- Screening for cervical cancer (annual PAP smear);
- Screening for breast cancer (mammography), subject to the limitations specified in the *Schedule of Benefits for Covered Health Care Services*;
- Screening for colorectal cancer age, subject to the limitations specified in the *Schedule of Benefits for Covered Health Care Services*.
- Screening for prostate cancer subject to the limitations specified in the *Schedule of Benefits for Covered Health Care Services*.
- Flu vaccine for Members who are 50 years or older OR when it is Medically Necessary for Members under age 50 with chronic illness such as diabetes, heart disease, moderate to severe asthma, renal failure, cancer or AIDS.

For a complete description of the Preventive Care Services covered under the Plan, refer to the Special Benefit Provisions section of this Member Handbook.

SPECIALTY CARE

All specialty care must be authorized 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;
- annual well woman examinations 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 authorization 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.

WELL WOMAN EXAMINATIONS

You do not need a referral to see a BlueLincs Participating Provider for your annual “well woman” exam. This exam includes a pap smear, a pelvic exam and an occult blood lab once every twelve months. Routine mammograms are also covered without a referral, subject to the limits shown in the *Schedule of Benefits for Covered Health Care Services*. Any follow-up care required after your routine “well woman” exam (including mammography screening) must be coordinated by your PCP. If you need additional specialty care, your PCP will refer you to a BlueLincs Participating Provider within the BlueLincs Network.

WELL MAN EXAMINATIONS

You do not need a referral to see a BlueLincs participating urologist for your annual “well man” exam. This exam includes an office visit, a prostate exam and an occult blood lab once every twelve months. Any follow-up care required after your routine “well man” exam (including a PSA test) must be coordinated by your PCP. If you need additional specialty care from a urologist, your PCP will refer you to a BlueLincs participating urologist within the BlueLincs Network.

HOSPITAL SERVICES

Hospital Services must be approved by your PCP and BlueLincs. 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.

EMERGENCY CARE

BlueLincs defines Emergency Care as treatment for any injury, illness or condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a reasonable and prudent layperson could expect the absence of medical attention to result in:

- serious jeopardy to the Member’s health;
- serious impairment to bodily function; or
- serious dysfunction of any bodily organ or part.

Examples include, but are not necessarily limited to: major trauma, loss of consciousness, suspected heart attacks, severe abdominal or chest pains, fractures, uncontrolled bleeding, burns, attempted suicide or poisonings.

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.

If you need Emergency Care, 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.

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.

If you need Urgent Care, place a call to your PCP to explain the illness or injury. Your PCP may instruct you in a method of home care, ask you to come to the office or advise you to go to a minor Emergency Care center or emergency room. Use of the minor Emergency Care center or emergency room for Urgent Care that is not Preauthorized by your PCP is not covered. 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 Covered 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 Physician or Hospital, you have access to a 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.bcbs.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.

Special Benefit Provisions

Subject to the exclusions, conditions and limitations of this Member Handbook, Benefits will be provided in accordance with the special provisions below.

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:
 - 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. Benefits include the rental (or, at BlueLincs’ option, the purchase) of manual or electric breast-feeding equipment.
 - 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 (tubal ligation), but not including hysterectomy.

Coverage includes contraceptives in the following categories:

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

NOTE: Prescription contraceptive medications are covered under the *Outpatient Prescription Drug Benefits* section of 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 Information list. You may access the Web site at www.bcbsok.com or contact Customer Service at the toll-free number on your Identification Card.

When obtaining the items noted above, you may be required to pay the full cost and then submit a claim form with itemized receipts to 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).

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, bone density test, screening for prostate cancer and colorectal cancer, smoking cessation counseling services, healthy diet counseling and obesity screening/counseling.

Examples of covered immunizations included are Diphtheria, Haemophilus influenza 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.

SERVICES RELATED TO TREATMENT OF AUTISM AND AUTISM SPECTRUM DISORDERS

- Subject to the *Exclusions*, conditions and limitations of this Member Handbook (including the Copayment, Coinsurance and/or Deductible provisions set forth in the *Schedule of Benefits for Covered Health Care Services*), Benefits will be provided for evaluation and management procedures, including Speech Therapy, Physical Therapy and Occupational Therapy, for treatment of autism and autism spectrum disorders, *limited to the following diagnoses*:
 - Autistic disorder — childhood autism, infantile psychosis and Kanner's syndrome;
 - Childhood disintegrative disorder — Heller's syndrome;
 - Rett's syndrome; and
 - Specified pervasive developmental disorders — Asperger's disorder, atypical childhood psychosis and borderline psychosis of childhood.
- Benefits for treatment of autism and autism spectrum disorders are subject to the following limitations:
 - **Members under age six** shall be entitled to the Benefits specified in the *Schedule of Benefits for Covered Health Care Services* for Physical Therapy, Occupational Therapy and Speech Therapy per Benefit Period.

- **Members age six and older** are subject to the limitations for Outpatient Physical Therapy, Occupational Therapy and Speech Therapy per Benefit Period, as specified under “**Special Services**” as set forth in the *Schedule of Benefits for Covered Health Care Services*.

HUMAN ORGAN, TISSUE AND BONE MARROW TRANSPLANT SERVICES

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

Preauthorization 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 that Preauthorization is obtained. Failure to obtain Preauthorization will result in denial of Benefits. BlueLincs has the sole and final authority for approving or declining requests for Preauthorization.

• 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.

– **Preauthorization**

Certification from BlueLincs HMO that, based upon the information submitted by the Member's attending Physician, Benefits will be provided under the Agreement. Preauthorization is subject to all conditions, exclusions and limitations of the Agreement. Preauthorization 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 the Agreement, (including the Copayment, Coinsurance and/or Deductible provisions set forth in the **Schedule of Benefits for Covered 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;
- 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 BlueLincs HMO's written medical policies.
- In addition to the Exclusions set forth elsewhere in the Agreement and the 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 BlueLincs HMO's written medical policies.
- Any organ or tissue transplant or Bone Marrow Transplant procedure which BlueLincs HMO considers to be Experimental/Investigational/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 the Agreement.
- When only the recipient is a Member, both the donor and the recipient are entitled to the Benefits of the 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 charged against the recipient's coverage under the Member Handbook.
- When only the living donor is a Member, the donor is entitled to the Benefits of the 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 or 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/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.

MASTECTOMY AND RECONSTRUCTIVE SURGERY

Subject to the *Exclusions*, conditions and limitations of this Member Handbook (including the Copayment, Coinsurance and/or Deductible provisions set forth in the *Schedule of Benefits for Covered 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 lymphedemas.

SERVICES RELATED TO CLINICAL TRIALS

Subject to the *Exclusions*, conditions and limitations of this Member Handbook (including the Copayment, Coinsurance and/or Deductible provisions set forth in the *Schedule of Benefits for Covered Health Care Services*), Benefits will be provided 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 cost of the investigational item, device or service;
- The cost of items and services provided solely to satisfy data collection and analysis needs and that are not used in direct clinical management;
- The cost for a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
- The cost for a clinical trial that does not meet criteria established by applicable law.

DIABETES EQUIPMENT, SUPPLIES AND SELF-MANAGEMENT SERVICES

- Subject to the *Exclusions*, conditions and limitations of this Member Handbook (including the Copayment, Coinsurance and/or Deductible provisions set forth in the *Schedule of Benefits for Covered Health Care Services*), Benefits will be provided for the following equipment, supplies and related services for the treatment of Type I, Type II, and gestational diabetes when Medically Necessary and when recommended or prescribed by a Physician or other Provider:
 - Blood glucose monitors;
 - Blood glucose monitors to the legally blind;
 - Test strips for glucose monitors;
 - Visual reading and urine testing strips;

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

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

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

Coverage for the equipment, supplies and self-management services specified above shall be provided in accordance with the terms and conditions of the appropriate **Schedule of Benefits** of this Member Handbook, including the *Schedule of Benefits for Outpatient Prescription Drugs and Related Services*.

AUDIOLOGICAL SERVICES AND HEARING AIDS

Benefits will be provided to Members, up to age 18, for Audiological services and hearing aids, limited to every 48 months for each hearing impaired ear; however, for children up to two years of age, up to four additional ear molds are available. Hearing aids must be prescribed, filled and dispensed by a licensed

This certificate is only a representative sample and does not constitute an actual insurance policy or contract.

audiologist. Benefits are subject to Copayment, Coinsurance and/or Deductible provisions of the Group Master Agreement.

WIGS OR OTHER SCALP PROSTHESES

Benefits shall include coverage for wigs or other scalp prostheses which are necessary for the comfort and dignity of the Member, and which are required due to hair loss resulting from radiation therapy or chemotherapy. Benefit are limited to two per Member per Benefit Period. Benefits are subject to the Copayment, Coinsurance and/or Deductible provisions of the Group Master Agreement.

Sample

This certificate is only a representative sample and does not constitute an actual insurance policy or contract.

Outpatient Prescription Drug Benefits

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 Drug Benefits* 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.

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 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*.

MAIL-ORDER PHARMACY PROGRAM

The Plan has selected a Mail-Order Pharmacy Program to fill and deliver maintenance (long-term) medications. *You are encouraged to fill these Maintenance Prescription Drugs through the Mail-Order Pharmacy.*

The Mail-Order Pharmacy Program provides delivery of Maintenance Prescription Drugs directly to your home address. All items that are covered under the Mail-Order Pharmacy Program are the same items that are covered under the Retail Pharmacy Program and are subject to the same limitations and exclusions. **Items covered through a Specialty Pharmacy may not be 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 Web site 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.

COVERED SERVICES

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 *Schedule of Benefits for Outpatient Prescription Drugs and Related Services*.
- Benefits for Prescription Drugs are available to the Member only:
 - In accordance with a Prescription Order;
 - 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;
 - When dispensed by a Participating Pharmacy (except in Emergency situations).
- Benefits include the following Covered Services:
 - Injectable insulin, insulin syringes and blood glucose treatment strips.
 - Oral contraceptives, regardless of Medical Necessity (each month's supply of oral contraceptives is considered a separate prescription).
 - Prescription Drugs used and prescribed for the treatment of learning disabilities, including attention deficit disorder (ADD), attention deficit hyperactivity disorder (ADHD), behavioral and conduct disorders (e.g. Ritalin, Adderall) subject to the Plan's guidelines for *Preauthorization*.
 - Self-injectable Prescription Drugs (including chemotherapy) when dispensed by a Pharmacy. Self-injectable drugs will be subject to the Copayment and/or Deductible provisions. Self-injectable drugs purchased from a Physician and administered in his/her office are not covered.
 - Oral chemotherapy when prescribed by a licensed Physician. Oral Chemotherapy will be subject to the Copayment, Coinsurance and/or Deductible provisions. 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), limited to a 30-day supply per Prescription Order. Specialty Pharmacy Drugs will be subject to the Copayment and/or Deductible provisions.
 - Vaccinations administered by a Participating Retail Pharmacy Vaccination Network Provider. **Vaccinations administered by a Pharmacy that is not a Participating Retail Pharmacy Vaccination Network Provider are not covered under the Schedule of Benefits for Outpatient Prescription Drugs and Related Services.** Visit the Blue Cross and Blue Shield of Oklahoma Web site at www.bcbsok.com for a current listing of vaccines available through this program.

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 orders the Prescription Drug to treat a covered emergency condition (as determined by BlueLincs); or
 - The Member’s Physician 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 Drug Benefits* 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 orders the Specialty Pharmacy Drug to treat a covered emergency condition (as determined by BlueLincs);
 - Your Physician 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 or unit dosage 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

For each Copayment and/or Coinsurance amount specified for your Prescription Drug Program, 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:

- During each one-month period, up to a 30-day supply or 120 units (e.g. pills), whichever is less, for “non-maintenance” and Specialty Pharmacy Drugs. If more than 120 units are needed to reach a 30 day supply, another Copayment or Coinsurance amount will apply to each additional 120 units (or portion thereof) purchased.
- During each three-month period, up to a 90-day supply or 360 units (e.g. pills), whichever is less, for drugs designated by BlueLincs as Maintenance Prescription Drugs. If less than a 90-day supply is ordered, the mail-order Copayment or Coinsurance will still apply. If more than 360 units are needed to reach a 90-day supply, an additional mail order Copayment or Coinsurance amount will apply to each additional 360 units (or portion thereof) purchased.

For commercially packaged items (such as an inhaler, a tube of ointment or a blister pack of tablets or capsules), you will pay the applicable Copayment or Coinsurance amount for each package, regardless of the days' supply the package represents. For example, if two inhalers are purchased under the retail Pharmacy, two Copayment or Coinsurance amounts will apply. Under the mail-order program, you can receive up to three times the number of packages obtainable from a retail Pharmacy for the applicable mail-order Copayment or Coinsurance amount.

A separate Copayment and/or Coinsurance amount will apply to each fill of a medication having a unique strength, dosage or dosage form.

A separate Copayment and/or Coinsurance amount will apply to each fill of a prescription purchased on the same day for insulin and insulin syringes.

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 has been used by the Member.

If you are leaving the country or need an extended supply of medication, call Customer Service at least two weeks before you intend to leave. Extended supplies or vacation overrides are not available through the **Mail-Order Pharmacy Program** but may be approved through a retail Pharmacy only. In some cases, you may be asked to provide proof of continued enrollment eligibility under this Prescription Drug program.

- **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, 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, identify gender 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 Preauthorization 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 treatment guidelines, any benefits for additional drugs may be subject to a review for Medical Necessity, appropriateness and other restrictions.

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 Drug Benefits** section for:

- 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.

- Devices or Durable Medical Equipment of any type (even though such devices may require a Prescription Order), such as, but not limited to, contraceptive devices, therapeutic devices, artificial appliances, or similar devices (**except** glucose meters, lancets, test strips and disposable hypodermic needles and syringes for self-administered injections.) However, coverage for prescription contraceptive devices is provided under the medical benefits provisions of your Member Handbook.
- Administration or injection of any drugs (except for 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'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; 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 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 Drug Benefits*** section; or refills of any prescriptions in excess of the number of refills specified by the Physician or by law; or any drugs or medicines dispensed more than one year following the Prescription Order date.
- Drugs which are not approved by the U.S. Food and Drug Administration (FDA) for a particular use or purpose or when used for a purpose other than the purpose for which the FDA approval is given, except as required by law or regulation. This exclusion is not applicable to the coverage of the off-label use of Prescription Drugs for the treatment of cancer or the study of oncology in accordance with Oklahoma law.
- 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 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 retain or alter 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.
- Athletic performance enhancement drugs.
- Drugs used or intended to be used in the treatment to stimulate growth, including, but not limited to, self-administered injectable 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 substances made by mixing, reconstituting or other such acts, not in accordance with directions contained in Food and Drug Administration (FDA) approved labeling provided by the product's manufacturer and other FDA-approved manufacturer directions consistent with that labeling.
- Replacement of drugs or other items that have been lost, stolen, destroyed, or misplaced.
- Shipping, handling, or delivery charges.
- Non-sedating antihistamine drugs and combination medications containing a non-sedating antihistamine and decongestant.
- Drugs which are repackaged by anyone other than the original manufacturer.

BRAND NAME EXCLUSION

Some equivalent drugs are manufactured under multiple brand names and have many therapeutic equivalents. In such cases, BlueLincs may limit Benefits to only one of the brand or therapeutic equivalents available. If you do not accept the brand or therapeutic equivalent that is covered under your Prescription Drug program, the drug purchased will not be covered under any benefit level.

PHARMACY DISCOUNT PROGRAMS

In an effort to help offset the rising cost of Prescription Drugs, drug manufacturers may offer coupons or other drug discounts or rebates to Members, which may impact the Benefits provided under this program. The total benefits payable will not exceed the balance of the allowable charges remaining after all drug coupons, rebates or other drug discounts have been applied. You agree to reimburse BlueLincs any excess amounts for Benefits that we have paid and for which you are not eligible due to the application of drug coupons, rebates or other drug discounts.

PRESCRIPTION DRUG PREAUTHORIZATION PROCESS

BlueLincs has designated certain drugs which require Preauthorization in order for Benefits to be provided under this Member Handbook. Preauthorization helps to assure that your Prescription Drug meets BlueLincs' guidelines for Medical Necessity for the condition being treated.

A form of Preauthorization is our Step Therapy program — a "step" approach to providing Benefits for certain medications your Physician prescribes for you. This means that you may first need to try one or more "prerequisite" medications before certain high-cost medications are approved for coverage under your Prescription Drug program.

If your Physician prescribes a drug requiring prior approval, you may obtain your prescription from a Participating Retail Pharmacy by following one of the following steps:

- ***You may obtain approval prior to going to the Pharmacy to have your prescription filled.***

You can obtain a listing of the drugs which require Preauthorization 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
P.O. Box 3283
Tulsa, OK 74121-1128

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

If your Physician prescribes a drug which requires prior approval, you or the Physician may request Preauthorization by calling the BlueLincs Customer Service number shown on your Identification Card.

When you present your prescription 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 Preauthorization request is approved prior to your trip to the Participating Retail Pharmacy, your pharmacist will dispense the Prescription Drug as prescribed and collect any applicable Copayment, Coinsurance and/or Deductible amounts.

If the Preauthorization request is denied, the pharmacist will receive an electronic message indicating that Benefits are not available for the drugs. You will be responsible for the full cost of your prescription.

- ***Your Participating Retail Pharmacy may begin the Preauthorization process for you.***

If you do not request approval of a drug before you go to the Participating Retail Pharmacy to have your prescription filled, your pharmacist will begin the Preauthorization process when you present your BlueLincs Identification Card with your Prescription Order. When the pharmacist submits your claim electronically, he/she will receive a message indicating that Preauthorization is required.

At this point, you may request a three-day supply of the drug while BlueLincs completes the approval process. Your pharmacist will collect the appropriate Copayment, Coinsurance and/or Deductible amount from you at the time of purchase.

Once the three-day supply has been used, you may return to the Pharmacy to obtain the remainder of your Prescription Order. The Participating Retail Pharmacy will resubmit the claim electronically to determine whether the Preauthorization request has been approved or denied.

- If Preauthorization is approved for the drug, you may obtain the full Prescription Order, subject to any Copayment, Coinsurance and/or Deductible amount applicable to the balance of the drug quantity dispensed.

This certificate is only a representative sample and does not constitute an actual insurance policy or contract.

- If the Preauthorization is denied, you may obtain the Prescription Order by paying the full cost for the drugs.
- Regardless of BlueLincs' decision, you will be notified in writing regarding the outcome of your Preauthorization approval request.

If you purchase your prescriptions from a nonparticipating pharmacy, or if you fail to present your Identification Card to a Participating Retail Pharmacy at the time of purchase, 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:

BlueLincs HMO
Customer Service Department
P. O. Box 3283
Tulsa, Oklahoma 74102-3283

To view a listing of the drugs which are included in the Preauthorization/Step Therapy program, please visit our Web site at www.bcbsok.com. If you have questions about Step Therapy, or any other aspects of the Preauthorization process, please call the number shown on your Identification Card for assistance.

TERMINATION OF BENEFITS

When you cease to be eligible for coverage, as defined in the Agreement, *Outpatient Prescription Drug Benefits* 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.

This certificate is only a representative sample and does not constitute an actual insurance policy or contract.

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 Physician.
 - Expenses incurred while not covered by this Member Handbook.
 - Services which BlueLincs determines are Experimental/Investigational/Unproven in nature.
 - Any condition to the extent benefits would have been provided under Medicare if the Member had applied for Medicare and claimed Medicare benefits, or to the extent governmental units provide benefits (some state or federal laws may affect how this exclusion is applied).
 - Procedures, services and supplies related to sex transformation.
 - Physical examinations for obtaining or for continuing employment, insurance, government licensing, flight, camp, school or athletics, or immunizations for international travel.
 - Services (except artificial insemination) related to conception by artificial means, including in vitro fertilization and embryo transfers or reversal of voluntary, surgically-induced sterility.
 - 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, including cleft lip and cleft palate.
- In no event will any care and services for breast reconstruction or implantation be a Covered Service unless such care and services are performed solely and directly as a result of mastectomy or other Medically Necessary procedure.
- Hearing aids, except as specified for Members under age 18.
 - Supportive devices for the feet, except for podiatric appliances for prevention of complications associated with diabetes.
 - 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 or contact lenses (including the fitting of the lenses) except as may be specifically provided for in the *Schedule of Benefits for Covered Health Care Services* or a supplemental *Vision Care Schedule of Benefits*. Refractive surgery is excluded.
 - Expenses for or related to transplantation of donor organs, tissues or bone marrow, except as may be specifically provided for in the Group Master Agreement. All transplants must be authorized in advance by BlueLincs.
 - Collection and storage of blood products or tissues.
 - Custodial Care, respite care, homemaker services, domiciliary or convalescent care.

- Personal convenience or comfort items or services.
- 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.
- Services, supplies or charges related to Inpatient treatment for any non-covered dental procedure, except that coverage shall be provided for Hospital Services, Ambulatory Surgical Facility Services and anesthesia services associated with any Medically Necessary dental procedure when provided to a Member who is;
 - severely disabled; or
 - eight years of age or under, and who has a medical or emotional condition which requires hospitalization or general anesthesia for dental care; or
 - four years of age or under, 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.
- Orthognathic Surgery, osteotomy of the mandible or maxillae, correction of malocclusion, correction of malpositions of the teeth, and items or services for care, treatment, filling, removal, replacement or artificial restoration of the alveolar processes, gums, jaws or associated structures except for:
 - the treatment of accidental injury to the jaw, sound natural teeth, mouth or face; or
 - for the improvement of the physiological functioning of a malformed body member resulting from a congenital defect, including cleft lip and cleft palate.
- 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.
- Drugs, including Prescription Drugs, except as may be covered under the ***Outpatient Prescription Drug Benefits*** section, if applicable. Inpatient drugs are covered. Insulin and diabetic supplies for diabetics are covered.
- Surgical procedures, services or charges related to weight reduction.
- Dietary control programs, including but not limited to the following: the dietary control program; Prescription or non-Prescription Drugs, or medications such as vitamins (whether to be taken orally or by injection), minerals, appetite suppressants, or nutritional supplements; or any other treatment.
- Provision of human or synthetic growth hormone or Outpatient provision of total parenteral nutrition, hyperalimentation unless authorized in advance by BlueLincs (administration and supervision are covered). Nutritional products, including supplements or replacements, for enteral or oral intake are excluded.
- 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.
- Evaluation and treatment of mental retardation (except for medical treatment) or evaluation and treatment of learning disabilities, including attention deficit disorder and behavioral and conduct disorder. This exclusion shall not apply to the following Medically Necessary services: (a) Physicians' services (except for neuropsychological testing) related to the diagnosis and treatment of attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD); or (b) Prescription Drug therapy (provided the Agreement includes supplemental benefits for Prescription Drugs) for treatment of ADD/ADHD, subject to BlueLincs' guidelines for Preauthorization.
- Psychological testing when not Medically Necessary to determine the appropriate treatment of a short-term psychiatric condition or psychological testing or therapy when it is court-ordered or as a condition of parole or probation.
- Medical Services for which the Member declines to authorize release of information to BlueLincs.
- Work or exercise related equipment.
- Genetic analysis, including DNA studies, chromosomal banding and gene identification studies, except when there are signs and/or symptoms of an inherited disease in the affected individual, the diagnosis would remain uncertain without such testing, the testing will impact the care and management of the affected individual and is authorized in advance by BlueLincs. BlueLincs will cover amniocentesis for use only in women age 35 or older OR for those women with a family history of inherited genetic disorders. Gene therapy is excluded.
- Administrative fees for dialysis.
- Physician standby services.
- Equipment not used exclusively for medical treatment such as: air-cleaning machines or air-filtering systems recommended for allergies; bed wetting alarm monitor devices; earplugs; hot tubs; hand-held shower attachments. Other items may be excluded, as well.
- Health care services provided by an immediate family member.
- Telephone, email or other electronic consultations, 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 the following surgical procedures: total knee arthroplasty, anterior cruciate ligament reconstruction, or open reduction and internal fixation of tibial plateau for distal femur fractures involving the knee joint.
- Ductal lavage of the mammary ducts.
- 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).
- Services not specifically named in the *Schedule of Benefits for Covered Health Care Services*.

This certificate is only a representative sample and does not constitute an actual insurance policy or contract.

- Inpatient drug and alcohol 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.
- Services, supplies or charges related to unspecified developmental disorders or autistic disease of childhood, except as specified in the Special Benefit Provisions Section.
- Services, supplies or charges related to applied behavior analysis.
- Female contraceptive devices when not prescribed by a licensed Provider, including over-the-counter contraceptive products. Contraceptive medications or devices for male use are excluded.
- For elective abortion, unless the life of the mother is endangered.

Sample

This certificate is only a representative sample and does not constitute an actual insurance policy or contract.

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.

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/Unproven. BlueLincs medical policies are used as guidelines for coverage determinations in health care benefit programs 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 utilization review of the care and services provided to you to determine the Medical Necessity and benefit eligibility of the services rendered. The fact that a Physician may recommend or approve a service, prescription or supply does not, of itself, make it Medically Necessary or make the charge a Covered Service, even though it is not specifically listed as an exclusion. However, BlueLincs will not seek reimbursement from a Member for the cost of any Benefit provided for Covered Services under the Agreement found to have been not Medically Necessary, provided that:

- the proper referral provisions of the Agreement were complied with; and
- the Member was not notified prior to the performance of the care and services that such care and services would not be Medically Necessary.

Utilization management decision-making is based only on appropriateness of care and service. The managed care organization does not compensate practitioners or other individuals conducting utilization review for denials of coverage or service. Financial incentives for utilization management decision-makers do not encourage denials of coverage or service.

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 100% of the base Medicare reimbursement rate. For services for which a Medicare reimbursement rate is not available, the Allowable Charge for Non-Contracting Providers will represent an average contract rate for 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 and will be updated not less than every two years. 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 BlueLincs.
 - Any Coinsurance amounts that are applicable to your coverage (*including the higher Coinsurance amounts which apply to non-Participating Provider services*).
 - 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 Plans and their Licensed Controlled Affiliates (“Licensees”). Whenever you obtain health care services outside of our Service Area, the claims for these services may be processed through one of these Plans.

Typically, when accessing care outside our Service Area, 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 health care Providers. Our reimbursement practices in both instances are described below.

BlueLincs covers only limited health care services received outside of our Service Area. As used in this section, “Out-of-Area Covered Health Care Services” include Emergency Care or Urgent Care obtained outside the geographic area we serve. Follow-up care following an emergency is also available, provided the services are preauthorized by BlueLincs. Any other services will not be eligible for Benefits unless authorized by BlueLincs.

- **BlueCard® Program**

Under the BlueCard® Program, when you obtain Out-of-Area Covered Health Care Services within the geographic area served by a Host Blue, the Host Blue is responsible for contracting with and generally handling all interactions with its participating health care Providers.

The BlueCard Program enables you to obtain services, as defined above, from a health care Provider participating with a Host Blue, where available. The participating health care 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 this Member Handbook and the *Schedule of Benefits*.

Whenever you access covered health care services outside our Service Area and the claim is processed through the BlueCard Program, the amount you pay for covered health care 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. Occasionally, it may be an average price for similar types of health care Providers.

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

Federal law or the laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If federal law or any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your responsibility for any Covered Services according to applicable law.

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

- **Your Liability Calculation**

When Out-of-Area Covered Health Care Services are received from non-participating Providers, the amount you pay for such services will generally be based on either the Host Blue's non-participating Provider local payment or the pricing arrangements required by applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating Provider bills and the payment we will make for the Covered Services as set forth in this Member Handbook.

- **Exceptions**

BlueLincs may determine the amount we will pay for services rendered by non-participating health care Providers, if pricing arrangements are not available from the Host Blue or applicable state law. In these situations, you may be liable for the difference between the amount that the non-participating Provider bills and the payment we will make for the Covered Services as set forth in this Member Handbook.

NOTE: BlueLincs may postpone or waive application of your 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.

INABILITY TO PROVIDE BENEFITS

If BlueLincs becomes unable to provide Benefits under this Plan due to events that are not reasonably within BlueLincs' control, such as complete or partial destruction of facilities, war, public disaster or emergency or general epidemic, BlueLincs will first attempt to provide services in non-BlueLincs facilities in the BlueLincs Service Area. If BlueLincs becomes unable to provide Benefits under this Plan, BlueLincs may, upon approval of the Oklahoma Insurance Department or other required agency, terminate the Agreement after 60 days' general notice of such condition to Members. During this period, BlueLincs will be liable for payment, up to 30 days, of all Covered Services under this Plan for any Member who is hospitalized for reason of Medical Necessity until the Member is discharged from the Hospital.

AGENCY RELATIONSHIPS

The Group is your agent, not our agent.

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

BLUELINC/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.

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 on 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, blanket, franchise insurance coverage or any other insurance coverage permitted by state law or Oklahoma Insurance Department guidance;
 - Blue Cross, Blue Shield, Health Maintenance Organization and other prepayment coverage;

- Coverage under labor-management trustee 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; 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 be preauthorized or precertified 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, **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. This right of recovery is limited to 24 months after the payment is made, unless:
 - the payment was made because of fraud committed by you or your Provider;
 - you or your Provider has otherwise agreed to make a refund to BlueLincs for overpayment of the claim.

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.
- 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.

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.

BLUELINC'S 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).

To help you understand how BlueLincs' separate financial arrangements with Participating Prescription Drug Providers work, please consider the following example:

- Assume you have a prescription dispensed and the undiscounted amount of the Prescription Drug is \$100. How is the \$100 bill paid?
- You will have to pay the Copayment or Coinsurance amounts set out in this Member Handbook.
- However, for purposes of calculating your Coinsurance amount, the full amount of the Prescription Drug would be reduced by the discount. In our example, if the applicable discount were 20%, the \$100 Prescription Drug bill would be reduced by 20% to \$80 for purposes of calculating your Coinsurance amount.

- In our example, if your Coinsurance obligation is 30%, you will have to pay 30% of \$80, or \$24. You should note that your 30% Coinsurance amount is based upon the discounted amount of the prescription and not the full \$100 bill.

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 equals one weighted paid claim; each extended supply or mail order (including Mail Service) paid claim equals three weighted paid claims. However, BlueLincs pays Prime a Program Management Fee (“PMF”) on a per paid claim basis. “Funding Levers” means a mechanism through which BlueLincs funds the fees (net fee, ancillary fees and special project fees) owed to PBM. Funding Levers always include manufacturer administrative fees, mail order utilization, participating pharmacy transaction fees, and, if elected by BlueLincs, may include rebates and retail spread. BlueLincs’ net fee owed to Prime for core services will be offset by the Funding Levers. The Plan pays Prime the net fee for core services, ancillary fees and special project fees, offset by all applicable Funding Levers as agreed upon under the terms of its agreement with Prime. The net fee is calculated based on a fixed dollar amount per Weighted Paid Claim.

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 3% 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.

BLUELINC'S 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.

Your Rights and Responsibilities as a BlueLincs Member

As a BlueLincs Member, you have certain rights and responsibilities. Among them are:

- The right to receive information about BlueLincs, its services, its practitioners and Providers, and Members' rights and responsibilities.
- The right to receive or have arranged by your BlueLincs Provider all Medically Necessary care covered under your benefit package.
- The right to considerate and courteous care with respect for personal privacy.
- The right to be informed in clear, understandable language about your diagnosis, treatment options and prognosis.
- The right to be involved in decision-making concerning your treatment.
- The right to candid discussion of appropriate or Medically Necessary treatment options for your conditions regardless of cost or benefit coverage.
- The right to confidentiality of information concerning your treatment.
- The right to know the identity of all persons involved in your care.
- The right to refuse treatment and to be told of the medical consequences.
- The right to be informed of research projects involving your care and the right to refuse participation in them.
- The right to file a complaint, grievance or appeal and be given due process.
- The right to designate an authorized representative to act on your behalf in pursuing a benefit claim or appeal of an adverse benefit determination.
- The responsibility to work with your PCP in maintaining a satisfactory Physician-patient relationship.
- The responsibility to contact your PCP for authorization of care when you choose to use your Benefits.
- The responsibility to comply with the prescribed medical treatment.
- The responsibility to provide complete health status information for accurate diagnosis and appropriate treatment.
- The responsibility to keep appointments for care and give required cancellation notice.
- The responsibility to read and understand all materials concerning your health Benefits.
- The responsibility to notify your Employer and BlueLincs of any other Group coverage you have, and to cooperate with BlueLincs in its coordination of Benefits efforts.
- The responsibility to pay any required portion of your premium, as well as Copayment, Coinsurance and/or Deductible amounts required under your benefits coverage.
- The responsibility to call Customer Service, at the number shown on your Identification Card, whenever you are unsure of procedures or covered Benefits.

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 or Physician 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 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
P. O. Box 3283
Tulsa, Oklahoma 74102-3283

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

TIMELY FILING OF CLAIMS

Your Properly Filed Claim must be furnished to BlueLincs within 180 days after the end of the Benefit Period for which the claim is made. Failure to provide a Properly Filed Claim to BlueLincs within 180 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 within 30 days. This period may be extended one time for up to 15 additional days if BlueLincs determines that additional time is necessary due to matters beyond our control.

If we determine that additional time is necessary, you will be notified, in writing, prior to the expiration of the original 30-day period, that the extension is necessary, along with an explanation of the circumstances requiring the extension of time and the date by which BlueLincs expects to make the determination.

This certificate is only a representative sample and does not constitute an actual insurance policy or contract.

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, prior to the expiration of the initial 30-day period, of the specific information needed. You will have 45 days from receipt of the notice to provide the additional information. BlueLincs will notify you of its benefit determination within 15 days following receipt of the additional information.

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*.

Sample

This certificate is only a representative sample and does not constitute an actual insurance policy or contract.

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. 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. Within seven working days following BlueLincs' receipt of your request, you will receive written notification outlining your rights and the time frames for determination.

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, and determination of a request for Preauthorization, 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, administrative or protocol for the determination;
- A description of additional information which may be necessary to perfect an appeal and an explanation of why such material is necessary;
- A description of additional information which may be necessary to perfect an appeal and an explanation of why such material is necessary;

- Subject to privacy laws and other restrictions, if any, the identification of the claim, date of service, health care Provider, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used. Upon request, diagnosis/treatment codes with their meanings and the standards used are also available;
- An explanation of our internal review/appeals and external review processes (and how to initiate a review/appeal or external review);
- In certain situations, a statement in non-English language(s) that the written notice of the claim denial and certain other benefit information may be available (upon request) in such non-English language(s);
- In certain situations, a statement in non-English language(s) that indicates how to access the language services provided by us;
- The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for Benefits;
- Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
- An explanation of the scientific or clinical judgment relied on in the determination as applied to the claimant's medical circumstances, if the denial was based on Medical Necessity, Experimental/Investigational/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 3 days of oral notification; and
- Contact information for applicable office of health insurance consumer assistance or ombudsman.

TIMING OF REQUIRED NOTICES AND EXTENSIONS

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

- **“Urgent Care Claim”** is any pre-service request for benefit(s) that requires *Preauthorization*, as described in this 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 with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment.
- **“Pre-Service Claim”** is any non-urgent request for Benefits or a determination with respect to which the terms of the benefit plan condition receipt of the benefit on approval of the benefit in advance of obtaining Medical Care.
- **“Post-Service Claim”** is any request for a benefit that is not a “pre-service” claim, and whereby notification that a service has been rendered or furnished to you is submitted to 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
<i>If we deny your initial claim, we must notify you of the denial:</i>	
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 appeal 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
<i>If we deny your initial claim, we must notify you of the denial:</i>	
if the initial claim is complete, within:	15 days*
after receiving the completed claim (if the initial claim is incomplete), within:	30 days

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

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
<i>If we deny your initial claim, we must notify you of the denial:</i>	
if the initial claim is complete, within:	30 days*
after receiving the completed claim (if the initial claim is incomplete), within:	45 days

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

CLAIM APPEAL PROCEDURES

- Claim Appeal Procedures – Definitions**

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

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

- Urgent Care/Expedited Clinical Appeals**

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

Upon receipt of an expedited pre-service or concurrent clinical appeal, we will notify the party filing the appeal, as soon as possible, but no more than 24 hours after submission of the appeal, of all the

information needed to review the appeal. Additional information must be submitted within 24 hours of request. 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 Preauthorization, 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 its decision in accordance with the following procedure:

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

Appeal Coordinator – Customer Service Department
BlueLincs HMO
P.O. Box 3283
Tulsa, Oklahoma 74102-3283

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

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

- If you have any questions about the claims procedures or the review procedure, write to our Administrative Office Customer Service Representative at the number shown on your Identification Card.

- ***Timing of Appeal Determinations***

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

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

- ***Notice of Appeal Determination***

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

The written notice will include:

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

EXTERNAL REVIEW RIGHTS

If you receive an Adverse Benefit Determination, you may have a right to have our decision reviewed by independent health care professionals who have no association with us ***if our decision involved making a judgment as to the Medical Necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment.*** The request for an external review by an Independent Review Organization (IRO) must be submitted within four months after you receive notice of the internal appeal determination. You or your authorized representative may file a request for external review by

completing the required forms and submitting them directly to the address noted below. We will also provide the forms to you upon request.

Oklahoma Insurance Department
3625 NW 56th Street
Oklahoma City, OK 73112-4511
Telephone: 1-800-522-0071 or 405-521-2828

For a standard external review, a decision will be made within **45 days** of receiving your request. If you have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed, you may be entitled to request an **expedited external review** of our denial. If our denial to provide or pay for a health care service or course of treatment is based on a determination that the service or treatment is Experimental/Investigational/Unproven, you also may be entitled to file a request for external review of our denial.

There will be no charge to you for the IRO review. The IRO will notify you and/or your authorized representative of its decision, which will be binding on 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
3625 NW 56th Street
Oklahoma City, OK 73112-4511
<http://www.ok.gov/oid/Consumers/index.html>
Telephone: 1-800-522-0071 or 405-521-2828

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, 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, 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

ACTIVELY AT WORK

The active expenditure of time and energy in the services assigned by the Employer. An Employee is deemed to be Actively at Work on each day of a regular paid vacation, sick leave, an Employer holiday or on a regular nonworking day, if such Employee was Actively at Work on the work day preceding his or her Effective Date.

AGREEMENT

The Group Master Agreement (including the Group Application, *Schedule of Benefits* and any attachments and/or riders) issued to the Employer by BlueLincs.

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 Covered 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.

ALTERNATE HEALTH PLAN

An indemnity or traditional Group health insurance plan provided to eligible Employees of the Employer, whether fully insured or self-insured by the Employer.

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.

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.

BLUECARD

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

CALENDAR YEAR

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

COBRA CONTINUATION COVERAGE

Coverage under 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

An amount a Member must pay in connection with the delivery of Covered Services.

COVERED DRUG

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

- 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 entirely 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, may be eligible for Benefits and will be added to the applicable formulary. Benefits are available for Covered Drugs 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.

DURABLE MEDICAL EQUIPMENT

Items which can withstand repeated use, meet BlueLincs' criteria of Medical Necessity for the given diagnosis, are not useful to the patient in the absence of illness, injury or disease, and are appropriate for use in the patient's home.

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 and Termination* section.

EMERGENCY CARE

Treatment for an injury, illness or condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a reasonable and prudent layperson could expect the absence of medical attention to result in:

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

EMPLOYEE

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

EMPLOYER

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

EXPERIMENTAL/INVESTIGATIONAL/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.

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. In determining the brand or generic classification for Covered Drugs, the Plan uses the generic/brand status assigned by a nationally recognized provider of drug product database information. A list of Generic Drugs is available on the Plan's Web site at www.bcbsok.com. You may also contact a Customer Service Representative at the number shown on your Identification Card for more information.

GROUP

A number or Group of Subscribers who are employed by the Employer, who have been accepted by BlueLincs for coverage and whose premiums are remitted to BlueLincs by the Employer.

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 Federal Medicare law, 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.

HOSPITAL

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

- Is licensed;
- Mainly provides Inpatient diagnostic and therapeutic services under the supervision of Physicians;
- Has organized departments of medicine and major Surgery;
- Provides 24-hour nursing service. ; and
- Is not, other than incidentally, a:
 - Skilled Nursing Facility;
 - Nursing home;
 - Custodial Care home;
 - Health resort;
 - Spa or sanitarium;
 - Place for rest;
 - Place for the aged;
 - Place for the treatment of Mental Illness;
 - Place for the treatment of alcoholism or drug abuse;
 - Place for the provision of Hospice care;
 - Place for the provision of rehabilitation care; or
 - Place for the treatment of pulmonary tuberculosis.

HOSPITAL SERVICES

Services for registered bed patients or Outpatients.

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 is treated as a registered bed patient in a Hospital or Skilled Nursing Facility and for whom a room and board charge is made.

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 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 Primary Care Physician.

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 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.

MEMBER

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

NON-PREFERRED BRAND DRUG

A name-brand Prescription Drug which is subject to the Non-Preferred Brand Drug Copayment, Coinsurance and/or Deductible amounts designated in the *Schedule of Benefits for Outpatient Prescription Drugs and Related Services*.

MENTAL ILLNESS

An emotional or mental disorder in which a person's thoughts, feelings or actions are abnormally disturbed, regardless of whether the condition or causation has a physical or emotional (mental) basis.

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.

OUT-OF-POCKET MAXIMUM

The total amount of Copayment, 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.

The following services do not count toward the Out-of-Pocket Maximum:

- Outpatient Prescription Drugs;
- Non-authorized services rendered by a non-Participating Provider;
- Self-Referral Services (except as specified); or
- Other supplemental Benefits (including Vision).

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, please refer to BlueLincs' Web site 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 doctor of Medicine, Osteopathy or other healing art profession defined and authorized by Oklahoma statutes, who is duly licensed to practice as such and is in good standing with the Oklahoma Board of Osteopathic Examiners or other Oklahoma Board of Physician Examiners appropriate to the specified healing art profession.

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.

PREAUTHORIZATION

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

PREFERRED BRAND DRUG

A brand-name drug which has been designated by the Plan to be a part of its Preferred Prescription Drug Program and is subject to the Preferred Brand Drug Copayment, Coinsurance and/or Deductible amounts designated in the *Schedule of Benefits for Outpatient Prescription Drugs and Related Services*.

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 prescription."

Prescription Drug does not include maintenance Prescription Drugs labeled Schedule II, Schedule III, Schedule IV or Schedule V drugs by the U. S. Department of Justice, Drug Enforcement Administration, or any other Prescription Drug used for its psychotropic, antidepressant or antianxiety effects.

PRESCRIPTION ORDER

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

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 *Special Benefit Provisions* section.
- The Preventive Care Services described above may change as the USPSTF, CDC, and HRSA guidelines are modified.

PRIMARY CARE PHYSICIAN (PCP)

A Physician who provides primary care Medical Services as a general or family care practitioner, or in some cases as an internist or pediatrician, and who has contracted with BlueLincs to provide primary care Medical Services to Members.

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 required by BlueLincs.

PROVIDER

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

PSYCHIATRIC HOSPITAL

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

QUALIFYING EVENT

Any one of the following events, which, but for the COBRA Continuation Coverage provisions 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.

RESIDENTIAL TREATMENT CENTER

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

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 vaccinations to Members.

SELF-REFERRAL SERVICES

Services which are not provided or authorized in advance by the Member's Primary Care Physician (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 Department at the number shown on your Identification Card to determine if he or she is in the Service Area or log on to the Web site at www.bcbsok.com.

SKILLED NURSING FACILITY

A Provider which is primarily engaged in providing skilled nursing and related services on an Inpatient basis to patients requiring 24-hour skilled nursing services but not requiring confinement in an acute care general Hospital. Such care is rendered by or under the supervision of Physicians. A Skilled Nursing Facility is not, other than incidentally, a place that provides:

- minimal care, Custodial Care, ambulatory care, or part-time services; or
- care or treatment of Mental Illness, alcoholism, drug abuse or pulmonary tuberculosis.

SPECIAL ENROLLMENT PERIOD

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

SPECIALIST

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

SPECIALTY PHARMACY DRUGS

Prescription Drugs that are high cost and generally prescribed for use in limited patient populations or indications. These drugs are typically injected, but may also include high cost oral medications. In addition, patient support and/or education and special dispensing or delivery may be required for these drugs; therefore, they are difficult to obtain via traditional pharmacy channels. A considerable portion of the use and costs are frequently generated through office-based medical claims and may require complex reimbursement procedures. The list of Specialty Drugs is subject to change. To determine which drugs are Specialty Drugs, you should contact your Pharmacy, refer to the Web site 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.

SUBSCRIBER

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

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 person of the same age and sex.

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.

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
3625 NW 56th Street, Suite 100
Oklahoma City, OK 73112
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 EMPLOYER EXEMPTION AND ELIGIBLE ORGANIZATION ACCOMMODATION

A certification(s) may have been provided to Blue Cross and Blue Shield of Oklahoma that your Group Health Plan is established or maintained by an organization(s) that is a “religious employer(s)” as defined in 45 C.F.R. 147.131(a), as modified or replaced, and qualifies for a religious employer 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 Employer Exemption”). Provided that the Religious Employer 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 contraceptives services (please call Customer Service at the number on the back of your Identification Card for more information). Questions regarding the Religious Employer Exemption should be directed to your Group Administrator.

In addition, a certification(s) may have been provided to Blue Cross and Blue Shield of Oklahoma 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(b), 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 contraceptives services. 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.

This certificate is only a representative sample and does not constitute an actual insurance policy or contract.



BlueCross BlueShield of Oklahoma



Sample

bcbsok.com

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.

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This certificate is only a representative sample and does not constitute an actual insurance policy or contract.