



Member Handbook

For Employees of The University of Oklahoma

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Certificate

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 the Agreement. BlueLincs certifies that all persons who have met the four requirements below are covered by the Agreement:

- applied for coverage under the Agreement;
- 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 the Agreement.



Chief Executive Officer

BlueLincs HMO Welcomes You

Congratulations! You have selected a special kind of health care coverage from BlueLincs.

ABOUT 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.

BlueLincs directly 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 are for each type of service and what services are covered.

- **Supplemental Riders, if applicable**

Because of some state or federal laws or the special needs of your Employer, provisions called “riders” may be added to your Member Handbook. Be sure to check for a “rider”. It changes provisions or benefits in the Agreement and your Member Handbook.

- **Provider Directory**

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

- **ID Card(s)**

You will receive an identification card (ID 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 ID card showing a separate ID number.**

Carry your ID card at all times and present it to Providers of care when you need services. If it gets lost, call BlueLines Member Services at 1-888-881-4648 to request a new card. Any time you have a benefit change or change your PCP, a new ID card will be mailed to you.

Legal requirements govern the use of your ID card. You cannot let anyone else use your ID card. Doing so may result in immediate termination of your coverage. You may appeal by following the Member Complaints and Appeals procedures described in this Handbook.

HOW TO GET ANSWERS TO YOUR QUESTIONS

You usually will be able to answer your health care benefit questions by referring to this Member Handbook. If you need more help, just call BlueLines Member Services at 1-888-881-4648.

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 amounts required under your benefits coverage.
- The responsibility to call BlueLincs whenever you are unsure of procedures or covered benefits (1-888-881-4648).

How BlueLincs Works

YOUR PRIMARY CARE PHYSICIAN (PCP)

- **Choosing Your PCP**

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, 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 (www.bcbsok.com). If you do not have Internet access, you may obtain Provider information, including a listing of BlueLincs Providers, by contacting Member Services at 1-888-881-4648.

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 Member Services. 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 or write Member Services. **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, and referrals may be reviewed by their own Managed Care Committee.

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.

TYPES OF COVERED CARE

- **Routine Care**

When you need routine care, contact your PCP's office for an appointment. Show your ID card and pay any Copayments 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:

- Newborn and well child care;
- Periodic physical exams;
- Childhood immunizations (as recommended by the Centers for Disease Control);
- Adult immunizations;
- Vision and hearing screening;
- Screening for cervical cancer (annual PAP smear);
- Screening for breast cancer (mammography), subject to the limitations specified in the Schedule of Benefits;
- Screening for colorectal cancer, subject to the limitations specified in the Schedule of Benefits;
- Screening for prostate cancer, subject to the limitations specified in the Schedule of Benefits.

- **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 18 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 availability of any Provider cannot be guaranteed.

When visiting BlueLincs Participating Specialists, be sure to show your ID card and pay any required Copayments.

- **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. Any follow-up care required after your routine "well woman" exam 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 HMO 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 ID card and pay any required Copayments.

- **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.

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 ID 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 BlueLines 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 BlueLines' network operates. Refer to the Schedule of Benefits ("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 BlueLines. You will not have to complete a claim form or pay up front for your health services, except for those out-of-pocket expenses (noncovered services and Copayments) that you would pay anyway.

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

COPAYMENTS

You, as a Member, have a responsibility to pay Copayments as outlined in your Schedule of Benefits.

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

If you have any questions regarding the application of Copayments as it relates to your Plan, please contact Member Services at 1-888-881-4648.

OUT-OF-POCKET MAXIMUM

To make sure that your Copayments do not become a burden, there is a maximum amount of Copayments 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 Copayments for Covered Services. If you have Family Coverage, only two family Members need to reach the Out-of-Pocket Maximum.

Copayments for the following do not apply to the Out-of-Pocket Maximum: Prescription Drugs, certain Inpatient mental health services, alcohol and substance abuse services, nonauthorized services, services

provided by a nonparticipating Provider, Self-Referral Services, supplemental services and noncovered services.

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 Member Services Representative for help if you wish to designate an authorized representative. In the case of a Preauthorization/Precertification Request Involving Urgent Care, a health care professional with knowledge of your medical condition will be permitted to act as your authorized representative.

Preauthorization/Precertification

Preauthorization/Precertification 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 and/or the Medical Group's Managed Care Committee 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/Precertification process may be handled by BlueLincs, your PCP and/or your Medical Group. In any event, the process for obtaining Preauthorization/Precertification is as follows:

PREAUTHORIZATION/PRECERTIFICATION 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/Precertification within five days following receipt of the additional information.

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

PREAUTHORIZATION/PRECERTIFICATION REQUESTS INVOLVING URGENT CARE

A "Request Involving Urgent Care" is any request for medical care or 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.

A request will be deemed to involve Urgent Care if, in the opinion of your Physician, the application of the time periods for making non-urgent determinations would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

In case of a "Request Involving Urgent Care," a response will be given to you no later than 72 hours after receipt of the request, unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Group Health Plan. In the case of such a failure, you will be notified no later than 24 hours after receipt of your request of the specific information necessary to complete your Preauthorization/Precertification request. You will be given a minimum of 48 hours to provide the specified information. You will be notified of the response to your request no later than 48 hours after the earlier of:

- the receipt of the specified information; or
- the end of the 48-hour period you were given to provide the specified information.

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

PREAUTHORIZATION/PRECERTIFICATION REQUESTS INVOLVING EMERGENCY CARE

If you need Emergency Care, you should go to the nearest appropriate facility and call your PCP within 48 hours of the incident. Your PCP's telephone number can be found on your BlueLincs ID 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).

Schedule of Benefits

A. Physician Services

The benefits listed below will be provided to Members only when Medically Necessary Covered Services are performed, prescribed, directed or Preauthorized by the Primary Care Physician the Member has selected (unless otherwise specified in this Member Handbook).

	<u>COPAYMENT¹</u>
1. Primary Care Physician services (office or home visits)	\$25 per visit
2. Specialist Physician services	\$35 per visit
3. Outpatient Physician facility services	\$35 per visit
4. Inpatient Physician services	No Charge
5. Diagnostic, radiology, ultrasound and laboratory procedures (with Physician office visit)	No Charge
6. Diagnostic, radiology, ultrasound and laboratory procedures (without Physician office visit)	\$35 per visit
7. Influenza immunizations ²	No Charge
8. Adult immunizations (other than influenza) for Members age 19 and older	\$25 (\$35 Specialist) per visit ²
9. Childhood immunizations (for Members under age 19)	No Charge
10. Periodic physical examinations (one per Calendar Year)	\$25 per visit
11. Routine obstetrical/gynecological exam, including Pap smear (one per Calendar Year)	\$25 per visit ³
12. Routine prostate specific antigen (PSA) test and digital rectal exam (DRE) (one per Calendar Year for males age 40 or older)	\$25 per visit ³
13. Routine mammograms (limited to one baseline exam for females between ages 35-39 and one per Calendar Year for females 40 or older)	No Charge
14. Routine colonoscopy (limited to one per Calendar Year for Members age 50 and older)	\$100 per visit
15. Vision and hearing screening (one every 24 months)	\$25 per visit
16. Well child care	\$25 per visit
17. Allergy testing	\$35 per visit
18. Allergy injections	\$25 per visit
19. Allergy serum	No Charge
20. Services of a surgeon and an anesthesiologist, including surgical procedures in Physician offices	\$25 (\$35 Specialist) per visit
21. 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	No Charge
22. Injections or infusions administered in the office	\$25 (\$35 Specialist) per visit ³

¹ Copayments are to be collected at the time service is rendered or at the convenience of the Provider.

² Benefits for adult influenza immunizations effective September 1, 2009.

³ No additional Copayment is required if billed as part of Physician's office visit.

B. Inpatient Hospital and Skilled Nursing Facility Services

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

COPAYMENT¹

\$250 per admission

1. Inpatient Hospital Services including:
 - a. Unlimited number of days in a semiprivate room
Private room is also covered if determined Medically Necessary and prescribed in advance by the Participating attending Physician
 - b. Intensive Care/Coronary Care
 - c. Use of operating room and special treatment rooms
 - d. Drugs and medications
 - e. General nursing and ancillary services
 - f. Administration of blood, blood plasma and blood derivatives
 - g. X-ray, laboratory and diagnostic services
 - h. Nursery newborn services (Copayment does not apply to routine well-baby care)
 - i. Hospitalization for a Member who is severely disabled or eight years of age or under; and who has a medical or emotional condition which requires hospitalization or general anesthesia for dental care

2. Skilled Nursing Facility/Inpatient rehabilitation

\$250 per admission

3. Inpatient Hospice Services

\$250 per admission

C. Outpatient Hospital or Facility Services

COPAYMENT¹

1. Surgery
2. Diagnostic procedures, including complex imaging services such as MRI, CAT, and PET scans)
3. Injections or infusions
4. Radiation therapy or chemotherapy
5. Laboratory procedures
6. Dialysis
7. Other therapies and procedures

\$100 per surgery

\$35 per visit

\$35 per visit

No Charge

\$35 per visit

No Charge

\$35 per visit

D. Maternity Services & Family Planning

COPAYMENT¹

1. Physician services, including prenatal and postnatal care
2. Diagnostic, radiology, ultrasound and laboratory procedures
3. Hospital Services
4. Infertility testing & treatment (diagnosis and treatment of underlying cause only)
5. Voluntary sterilization (reversal is not covered)
6. Pregnancy termination (therapeutic and non-therapeutic)
7. Contraceptive devices including diaphragms and surgically implanted contraceptive devices (intrauterine devices and intradermal devices)

\$25 (\$35 Specialist) for initial visit only, then No Charge

\$35 per visit

Same as other Hospital Services

Subject to applicable Copayment

Subject to applicable Copayment

Subject to applicable Copayment

No charge for device; Insertion of device subject to applicable Copayment

- | | |
|---|-------------------------------------|
| E. Outpatient Urgent Care | <u>COPAYMENT</u>¹ |
| 1. Urgent services, supplies and medical treatment, whether in the Service Area or out of the Service Area, provided in an emergency room | \$100 per visit ² |
| 2. Participating minor emergency care centers | \$50 per visit |

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

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

- | | |
|--|--|
| F. Outpatient Emergency Care | <u>COPAYMENT</u>¹ |
| 1. Emergency services, supplies and medical treatment, whether in the Service Area or out of the Service Area, provided in an emergency room | \$100 per visit
(waived if admitted) ² |
| 2. Participating minor emergency care centers | \$50 per visit |

BlueLincs HMO defines Emergency Care as treatment for any injury, illness or condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a reasonable and prudent layperson could expect the absence of medical attention to result in: a) serious jeopardy to the Member’s health; b) serious impairment to bodily function; or c) serious dysfunction of any bodily organ or part. Examples include, but are not necessarily limited to: major trauma, loss of consciousness, suspected heart attacks, severe abdominal or chest pains, fractures, uncontrolled bleeding, burns, attempted suicide or poisonings.

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

G. Out of Area Benefits

If the Member needs Urgent Care and is traveling outside the BlueLincs HMO Service Area, but within the state of Oklahoma, follow the “Urgent Care” procedures described in Section E. If the Member needs Urgent Care and is traveling outside the state, call 1-800-810-BLUE (1-800-810-2583) or log on to www.bcbs.com to access the BlueCard[®] Program’s provider finder 24 hours a day.

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

¹ Copayments are to be collected at the time service is rendered or at the convenience of the Provider.

² This Copayment can only be waived if a Member is admitted to the Hospital through an emergency room visit.

H. Mental Illness Services

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

- | | <u>COPAYMENT</u> ¹ |
|---|-------------------------------|
| 1. Outpatient benefits include service in the office of a psychiatrist, clinical psychologist or psychiatric social worker for visits of one hour or less with a maximum of 20 visits per Calendar Year | \$35 per visit |
| 2. Inpatient benefits, including Physician services and Hospital Services, are available with a maximum of 30 Inpatient days per Calendar Year (two partial days can be exchanged for one Inpatient day). | \$250 per admission |

NOTE: Treatment of Severe Mental Illness is covered as any other illness, and the above limitations do not apply. Severe Mental Illness is limited to the following conditions: schizophrenia, bipolar disorder (manic-depressive illness), major depressive disorder, panic disorder, obsessive-compulsive disorder, and schizoaffective disorder.

I. Alcohol and Drug Abuse Services

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

- | | <u>COPAYMENT</u> ¹ |
|--|-------------------------------|
| 1. Outpatient emergency detoxification or rehabilitation for alcoholism or drug overdose when Medically Necessary (20 visit maximum per Calendar Year) | \$35 per visit |
| 2. Inpatient Hospital/Facility (30 day maximum per Calendar Year) | \$250 per admission |

J. Special Services

- | | <u>COPAYMENT</u> ¹ |
|--|-------------------------------|
| 1. Home Health Care Services provided by a Participating Home Health Care Agency, when recommended by the Member's Primary Care Physician and approved in advance by the BlueLincs Medical Director, but not including meals, housekeeping and personal convenience items (coverage for physical therapy, occupational therapy and speech therapy provided at home is described in Section J.8). | No Charge |
| 2. Hospice Care Services provided on an Outpatient basis by a Participating Hospice Provider when recommended by the Member's Primary Care Physician and approved in advance by the BlueLincs Medical Director. | No Charge |
| 3. Private duty nursing services when recommended by the Member's Primary Care Physician and approved in advance by the BlueLincs Medical Director. | No Charge |
| 4. Services related to the diagnosis of infertility and treatment of underlying cause, when referred by the Member's Primary Care Physician. Services must be performed by a Participating Provider. | \$35 per visit |

¹ Copayments are to be collected at the time service is rendered or at the convenience of the Provider.

Special Services (continued)**COPAYMENT¹**

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|--|---|
| 5. Dental services to sound natural teeth, and oral surgery benefits as set forth in the <u>“Special Benefit Provisions”</u> section of this <u>Member Handbook</u> . | Subject to applicable Copayment |
| 6. DME, including casts, splints, crutches, prostheses, oxygen supplies or other appliances/supplies used exclusively for medical treatment (foot orthotics are covered only if necessary to prevent complications from diabetes). | No Charge |
| 7. Ambulance service for Medically Necessary emergency transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured to the closest facility that can provide Covered Services appropriate to the Member’s condition. | Allowable Charges ¹
Covered in Full |
| 8. Physical therapy, occupational therapy and speech therapy when prescribed by the Member’s Primary Care Physician for conditions which are judged subject to significant improvement through short-term therapy and provided in an outpatient or home setting (<u>combined maximum 60 treatments per Calendar Year, including a 20-visit limit for speech therapy visits related to treatment of autism</u>). | \$35 per visit |
| 9. Diabetes self-management training, including nutrition therapy for reasons other than weight reduction as a sole purpose | Subject to applicable Copayment |
| 10. Audiological services and hearing aids for Members up to age 18, limited to 2 every 24 months for each hearing-impaired ear; however, up to four additional ear molds are available for children up to two years of age. Hearing aids must be prescribed, filled and dispensed by a licensed audiologist. | \$25 per visit |
| 11. Wigs or other scalp prostheses which are Medically Necessary for the comfort and dignity of the Member, and which are required due to hair loss resulting from radiation therapy or chemotherapy (<u>\$150 maximum per Calendar Year</u>). | No Charge |
| 12. Smoking cessation services, including over-the-counter medications, acupuncture, hypnosis, and other stop smoking aids (\$500 maximum per Calendar Year; \$1,500 maximum per lifetime). Prescription medications are covered as outlined in the Schedule of Benefits for Outpatient Prescription Drugs. | No Charge |

K. Annual Out-of-Pocket Maximum

Annual Out-of-Pocket Maximum, per Member, per Calendar Year	\$2,000
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This Out-of-Pocket Maximum does not include Copayments for Prescription Drugs, certain mental health services, alcohol and drug abuse services, non-authorized services performed by a non-participating Provider, Self-Referral Services, supplemental services or noncovered services.

Family Coverage – After two covered family Members have reached the Out-of-Pocket Maximum in one Calendar Year, eligible expenses for those and other covered family Members will be paid in full during the remainder of that year.

This Out-of-Pocket Maximum does not include Copayments for prescription drugs, certain mental health services, alcohol and drug abuse services, non-authorized Services performed by a non-participating Provider. Self-Referral Services, supplemental services or noncovered services.

¹ Allowable Charge is the billed charge less any negotiated Provider discount.

L. Exclusions and Limitations

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

1. Services BlueLincs determines are not Medically Necessary.
2. Non-emergency services that are not authorized by the Member's Primary Care Physician.
3. Expenses incurred while not covered by this Plan.
4. Services which BlueLincs determines are Experimental/Investigational in nature.
5. Any condition to the extent payment would have been made under Medicare if the Member had applied for Medicare and claimed Medicare benefits, or to the extent governmental units provide benefits (some state or federal laws may affect how this exclusion is applied).
6. Procedures, services and supplies related to sex transformation.
7. Physical examinations for obtaining or for continuing employment, insurance, government licensing, flight, camp, school, or athletics.
8. Services (except artificial insemination) related to conception by artificial means, including in vitro fertilization and embryo transfers or reversal of voluntary, surgically-induced sterility.
9. Cosmetic surgery or complications resulting there from, including surgery to improve or restore personal appearance, unless: a) needed to repair conditions resulting from an accidental injury; or b) for the improvement of the physiological functioning of a malformed body member (including cleft lip and cleft palate), except for services related to Orthognathic Surgery, osteotomy, or any other form of oral surgery, dentistry or dental processes to the teeth and surrounding tissue not specifically covered as specified in the "Special Benefit Provisions" section of this Member Handbook. In no event will any care and services for breast reconstruction or implantation be a Covered Service unless such care and services are performed solely and directly as a result of mastectomy or other Medically Necessary procedure.
10. Hearing aids, except as specified for Members under age 18.
11. Supportive devices for the feet, except for podiatric appliances for prevention of complications associated with diabetes.
12. Repair and/or replacement of Durable Medical Equipment which is lost, damaged or destroyed due to improper use or abuse.
13. 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 this Schedule of Benefits. Refractive surgery is excluded.
14. Expenses for or related to transplantation of donor organs, tissues or bone marrow, except as may be specifically provided for in the Group Master Agreement. All transplants must be authorized in advance by BlueLincs.
15. Collection and storage of blood products or tissues.
16. Custodial Care, respite care (except when provided as part of covered hospice care program), homemaker services, domiciliary or convalescent care.
17. Personal convenience or comfort items or services.
18. Care provided outside the Service Area if the need for care could have been foreseen before departing the Service Area.
19. Medical and Hospital costs resulting from a normal, full-term delivery of a baby outside of the BlueLincs Provider Network.
20. Services, supplies or charges related to Inpatient treatment for any non-covered dental procedure, except that coverage shall be provided for Hospital Services, ambulatory surgical facility services and anesthesia services associated with any Medically Necessary dental procedure when provided to a Member who is severely disabled or eight years of age or under; and who has a medical or emotional condition which requires hospitalization or general anesthesia for dental care.
21. Orthognathic Surgery, osteotomy of the mandible or maxillae, correction of malocclusion, correction of malpositions of the teeth, and items or services for care, treatment, filling, removal, replacement or artificial restoration of the alveolar processes, gums, jaws or associated structures except for: a) the treatment of accidental injury to the jaw, sound natural teeth, mouth or face; or b) for the improvement of the physiological functioning of a malformed body member, including

- cleft lip and cleft palate; or c) Oral Surgery procedures specified in the “Special Benefit Provisions” section of this Member Handbook.
22. Inpatient or Outpatient care which is necessitated in whole or in part by a non-covered condition or service.
 23. Medical supplies such as dressings, antiseptic, needles, syringes (except for diabetics) and other over-the-counter items.
 24. Surgical procedures, services or charges related to weight reduction. Bariatric surgery is excluded except when ordered by the Primary Care Physician and in accordance with Medical Necessity requirements.
 25. Dietary control programs, including but not limited to the following: the dietary control program; prescription or nonprescription drugs, or medications such as vitamins (whether to be taken orally or by injection), minerals, appetite suppressants, or nutritional supplements; or any other treatment.
 26. 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.
 27. 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.
 28. 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) for Members age 19 and under; (b) prescription drug therapy (provided the Agreement includes supplemental benefits for Prescription Drugs) for treatment of ADD/ADHD in Members age 19 and under; or (c) for speech therapy related to autism (limited to 20 visits per Calendar Year).
 29. 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.
 30. Medical Services for which the Member declines to authorize release of information to BlueLincs.
 31. Work or exercise related equipment.
 32. 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.
 33. Administrative fees for dialysis.
 34. Physician standby services.
 35. Equipment not used exclusively for medical treatment such as: air-cleaning machines or air-filtering systems recommended for allergies; bed wetting alarm monitor devices; breast pumps; earplugs; hot tubs; hand-held shower attachments. Other items may be excluded, as well.
 36. Health care services provided by an immediate family member.
 37. Telephone, email or other electronic consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form.
 38. Family or marital counseling.

39. Hippotherapy, equine assisted learning, or other therapeutic riding programs.
40. 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.
41. Ductal lavage of the mammary ducts.
42. 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.
43. Orthoptic training.
44. Thermal capsulorrhaphy as a treatment of joint instability, including but not limited to instability of shoulders, knees and elbows.
45. Transcutaneous electrical nerve stimulator (TENS).
46. Services rendered by midwives.
47. Services not specifically named in this Schedule of Benefits or the Schedule of Benefits for Outpatient Prescription Drugs.

Special Benefit Provisions

HUMAN ORGAN, TISSUE AND BONE MARROW TRANSPLANT SERVICES

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

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

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.

- Precertification

Certification from BlueLincs that, based upon the information submitted by the Member's attending Physician, Benefits will be provided under the Agreement. Precertification is subject to all conditions, exclusions and limitations of the Agreement. Precertification 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, 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 for assessing and performing organ or tissue transplants, or Bone Marrow Transplant procedures, as set forth in BlueLincs' 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' written medical policies.
 - Any organ or tissue transplant or Bone Marrow Transplant procedure which BlueLincs HMO considers to be Experimental or Investigational 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 meet the criteria established by BlueLincs HMO for assessing and performing organ or tissue transplants, or Bone Marrow Transplant procedures.
- 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 Agreement.
- 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 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 or Investigational (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 the Agreement.

MASTECTOMY AND RECONSTRUCTIVE SURGERY

Subject to the exclusions, conditions and limitations of the Agreement (including the Copayment provisions set forth in the *Schedule of Benefits*), 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.

DIABETES EQUIPMENT, SUPPLIES AND SELF-MANAGEMENT SERVICES

- The following equipment, supplies and related services for the treatment of Type I, Type II, and gestational diabetes when Medically Necessary and when recommended or prescribed by a Physician or other Provider:
 - Blood glucose monitors;
 - Blood glucose monitors to the legally blind;
 - Test strips for glucose monitors;
 - Visual reading and urine testing strips;
 - 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).
- 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 reeducation 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.)

HOSPICE CARE BENEFITS

Your coverage includes benefits for services received in a Hospice Care Program. For benefits to be available for these services, they must have been ordered by your Primary Care Physician.

In addition, they must be rendered by a Hospice Care Program Provider. However, for benefits to be available you must have a terminal illness with a life expectancy of one year or less as certified by your Primary Care Physician; and you will no longer benefit from standard medical care, or have chosen to receive hospice care rather than standard care. Also, a family member or friend should be available to provide custodial type care between visits from Hospice Care Program Providers if hospice is being provided in the home.

The following services are covered under the Hospice Care Program:

- Skilled Home Health Care Services;
- Medical supplies and dressings;
- Medication;
- Nursing Services — Skilled and non-Skilled;
- Occupational Therapy;
- Pain management services;
- Physical Therapy;
- Physician visits;
- Social and spiritual services;
- Respite Care Services.

The following services are not covered under the Hospice Care Program:

- Durable Medical Equipment;
- Home delivered meals;
- Homemaker services;
- Traditional medical services provided for the direct care of the terminal illness, disease or condition;
- Transportation, including but not limited, to ambulance transportation.

Notwithstanding the above, there may be clinical situations when short episodes of traditional care would be appropriate even when the patient remains in the hospice setting. While these traditional services are not eligible under this Hospice Care Program section, they may be Covered Services under other sections of this Member Handbook.

Benefits are subject to the same payment provisions and day limitations specified in the Schedule of Benefits of this Handbook, depending upon the particular Provider involved (Hospital, Skilled Nursing Facility, Home Health Care Agency or Physician).

SEVERE MENTAL ILLNESS

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

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

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

Treatment of other Mental Illnesses will continue to be subject to the provisions for Mental Illness services set forth in the Schedule of Benefits.

ORAL SURGERY/DENTAL SERVICES FOR ACCIDENTAL INJURY

Subject to the exclusions, conditions and limitations of this Member Handbook (including the Copayment provisions set forth in the Schedule of Benefits), benefits will be provided for the following procedures performed by a Physician or Dentist:

- Surgical removal of completely bony impacted teeth;
- Excision of tumors or cysts from the jaws, cheeks, lips, tongue, roof or floor of the mouth;
- Surgical procedures to correct accidental injuries of the jaws, cheeks, lips, tongue, roof or floor of the mouth;
- Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses);
- Treatment of fractures of facial bones;
- External incision and drainage of cellulites;
- Incision of accessory sinuses, salivary glands or ducts;
- Reduction of dislocation of, or excision of, the temporomandibular joints;
- Services required due to accidental injury to sound natural teeth.

Schedule of Benefits for Outpatient Prescription Drugs

Per-prescription Copayment

Generic Drugs - \$10 Copayment¹

The Copayment will be applied as follows:

<u>Quantity Dispensed</u>	<u>Number of Copayments</u>
1 to 30 days	1 Copayment
31 to 90 days	2 Copayments

Preferred Drugs² - \$30 Copayment¹

The Copayment will be applied as follows:

<u>Quantity Dispensed</u>	<u>Number of Copayments</u>
1 to 30 days	1 Copayment
31 to 90 days	2 Copayments

Non-Preferred Brand Drugs - \$60 Copayment¹

The Copayment will be applied as follows:

<u>Quantity Dispensed</u>	<u>Number of Copayments</u>
1 to 30 days	1 Copayment
31 to 90 days	2 Copayments

Mail Order or Extended Day Supply – Pharmacy Provider Network

90-Day Supply Per Prescription Copayment

Generic Drugs	\$20
Preferred Drugs ²	\$60
Non-Preferred Brand Drugs	\$120

Specialty Drugs may not be dispensed through the mail-order program, except through a Participating Specialty Pharmacy.

Benefits

- 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 when recommended by and while under the care of a Participating Provider (or Medical Group Participating Provider), provided such care and treatment is Medically Necessary and is a Covered Service in the Group Master Agreement.

¹ Copayments are to be collected at the time service is rendered or at the convenience of the Provider.

² BlueLincs maintains a formulary of Preferred Drugs that have been reviewed and approved by a committee of Participating Physicians and pharmacists. Periodic changes to this formulary of Preferred Drugs are made by this committee.

- Benefits for Prescription Drugs are available to the Member only:
 1. In accordance with a Prescription Order.
 2. After the Member has incurred charges equal to the Copayment for each Prescription Order. If the charge for the Member's prescription is *less* than the Copayment, the Member will pay the lesser amount.
 3. When dispensed by a Participating Retail Pharmacy (except in Emergency situations).
- Benefits include:
 1. Injectable insulin and insulin products;
 2. Oral contraceptives, regardless of Medical Necessity
 3. Prescription Drugs prescribed for the treatment of attention deficit disorder or attention deficit hyperactivity disorder for Members age 19 and under, subject to Plan's guidelines for Precertification.
 4. Self-injectable Prescription Drugs, when dispensed by a Pharmacy. Self-injectable drugs purchased from a Physician and administered in his/her office are not covered.

Limitations on Benefits

- **Maximum Quantities:** Benefits will be provided for Prescription Drugs dispensed in the following maximum quantities:
 1. Up to a 30-day supply for one single Copayment¹ at any Participating Retail Pharmacy.
 2. Up to a 90-day supply or 360 unit doses (whichever is less) for two Copayments* at a Participating Retail Pharmacy.
 3. Up to a 30-day supply for one Copayment for Specialty Pharmacy Drugs obtained at a Participating Specialty Pharmacy. When Specialty Pharmacy Drugs are dispensed by a Pharmacy which is not a Participating Specialty Pharmacy, benefits are reduced to 70% of the Allowable Charge for the drugs, less the applicable Copayment.

Prescription Drug benefits are not provided under this Schedule of Benefits for charges for Prescription Drugs dispensed in excess of the above stated amounts.
- Benefits will not be provided for a Prescription refill until 75 percent of the prescribed dosage has been used.
- In order for a Prescription Drug obtained from a Non-Participating Pharmacy to be covered, the following criteria must be met:
 1. The Member is outside the Service Area and the Physician orders the Prescription Drug to treat a covered Emergency condition; or
 2. The Member's Primary Care Physician orders the immediate use of a Prescription Drug due to a Medical Necessity, and no Participating Retail Pharmacy is open or available.

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. 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.

Certain drugs require the Member to receive Preauthorization (Precertification) in order for benefits to be provided under the Group Master Agreement. Precertification may be requested by the Member or Physician before the drug is dispensed. BlueLincs may deny coverage for these drugs or specify that a limited quantity of the drugs be dispensed.

¹ Copayments are to be collected at the time service is rendered or at the convenience of the Provider.

Exclusions

No benefits will be provided under the Prescription Drug Benefits supplement for:

- Human growth hormones;
- Contraceptive devices (included under medical benefits—except for over-the-counter devices);
- Prescription vitamins (except prenatal vitamins taken during pregnancy);
- Appetite suppressants or other agents used for weight loss;
- Drugs used for treatment of learning disabilities, except for treatment of attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD) for Members age 19 and under;
- Needles and syringes (except insulin syringes);
- Non-prescription drugs (includes over-the-counter items)
- Medications or devices used to retain or alter hair growth;
- Drugs to treat sexual dysfunction;
- Drugs not FDA-approved;
- Drugs used for cosmetic purposes;
- 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.

Prescription Drug Benefits

PRESCRIPTION DRUG PRECERTIFICATION PROCESS

BlueLincs has designated certain drugs for which you must receive Precertification in order for benefits to be provided under the Prescription Drug benefits supplement. Precertification helps to assure that your Prescription Drug meets BlueLincs' guidelines for Medical Necessity for the condition being treated.

A form of Precertification 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 Precertification at www.bcbsok.com, or you may contact BlueLincs Member Services at 1-888-881-4648.

Please keep in mind that the listing of drugs requiring Precertification 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 Precertification by calling the BlueLincs Member Services number listed above.

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 Precertification 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 Deductible, Copayment and/or Coinsurance amount.

If the Precertification 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 Precertification 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 Precertification 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 Precertification 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 Deductible, Copayment and/or Coinsurance 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 Precertification request has been approved or denied.

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

If you purchase your prescriptions from a nonparticipating pharmacy, or if you fail to present your ID 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 the Prescription Order is written by a Participating Physician and 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
Member Services Department
P. O. Box 3283
Tulsa, Oklahoma 74102-3283

To view a listing of the drugs which are included in the Precertification/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 Precertification process, please call 1-888-881-4648 for assistance.

TERMINATION OF BENEFITS

When you cease to be eligible for coverage, as defined in the Agreement, 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.

PLAN'S SEPARATE FINANCIAL ARRANGEMENT WITH PHARMACY BENEFIT MANAGERS

Health Care Service Corporation owns a significant portion of the equity of Prime Therapeutics LLC and informs you that it has entered into one or more agreements with Prime Therapeutics LLC or other entities (collectively referred to as "Pharmacy Benefit Managers") to provide, on BlueLincs' behalf, claim

payments and certain administrative services for your Prescription Drug Benefits. Pharmacy Benefit Managers have agreements with pharmaceutical manufacturers to receive rebates for using their products. The Pharmacy Benefit Manager may share a portion of those rebates with BlueLincs. Neither the Employer nor you are entitled to receive any portion of such rebates as they are figured into the pricing of the product.

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

To be eligible to Enroll, an Eligible Person must reside or work in the BlueLincs Service Area. Eligible Persons include the following:

- **Full-time Employees** — Benefits-eligible Employees who receive 100% of the Sooner Credits provided by the University.
- **Part-time Employees** — Benefits-eligible Employees who are appointed to at least a 0.50 full-time equivalent (FTE).

Employees have 31 days from the first date of employment to make their benefit elections. Full-time, benefits-eligible Employees who fail to select benefits within the 31-day election period will be “enrolled” (defaulted) into the core insurance benefits coverage. Part-time, benefits-eligible Employees who hold a 0.75 FTE appointment or less cannot be defaulted into the University’s medical and dental plans and must make a plan election and enroll before coverage will begin.

WHO IS AN ELIGIBLE DEPENDENT

An Eligible Dependent is defined as:

- your spouse.
- your unmarried child, including the following:
 - a newborn child, adopted child or stepchild;
 - a child for whom you or your spouse is legally responsible, including a child on whose behalf a qualified medical child support (QMCSO) has been issued;
 - a child who lives with you, whose parent is your child and is covered as an Eligible Dependent under this Plan.

Unmarried Dependent children under age 19 are eligible for coverage until December 31 coinciding with or following their 19th birthday.

Unmarried Dependent children who are enrolled as Full-Time Students are eligible for coverage until the end of the month coinciding with or following their 25th birthday.

Unmarried Dependent children who are medically certified as Totally Disabled and dependent upon you or your spouse are eligible for coverage regardless of age.

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

BlueLincs also 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 your expense. BlueLincs will make the final determination as to whether the Dependent is Totally Disabled.

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 the enrollment process established by your Employer. Contact the Campus Benefits Office for additional information.

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 Employer).

INITIAL ENROLLMENT PERIOD

- Initial Group Enrollment

If you are an Eligible Person on the Agreement Effective Date and you Enroll 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 you Enroll 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.

- Initial Enrollment of New Dependents

You can apply to add Dependents to your coverage through the Campus Benefits Office within 31 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. You must request this coverage through the Campus Benefits Office within 31 days of the child's birth.
- If your coverage already includes Dependent children, please notify the Campus Benefits Office 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 you contact the Campus Benefits Office 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 you contact the Campus Benefits office 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 the Campus Benefits Office in order to add coverage for the child.

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 Group Health Plan on behalf of your children. An order or notice issued through a state administrative process that has the force of law may also provide for 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 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 Group Health Plan, except as otherwise required by law. You will

be responsible for paying all applicable premium contributions, and any Copayment or other cost sharing provisions that apply to your 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 the Campus Benefits Office or a BlueLincs Member Services Representative (1-888-881-4648) concerning these procedures.

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. A person who Enrolls during a Special Enrollment Period is not treated as a Late Enrollee.

- **Special Enrollment for Loss of Other Coverage**

The Special Enrollment Period for loss of other coverage is available to you and your Dependents who meet the following requirements:

- You and 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 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 request for special enrollment must be submitted through your Campus Benefits Office 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 your request is received.

NOTE: Be sure to include a copy of the Certificate of Coverage and any other 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. **Your special enrollment request must be submitted through the Campus Benefits Office 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 your request. 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 you request enrollment through the Campus Benefits Office 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.

OPEN ENROLLMENT PERIOD/LATE ENROLLEES

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 at any time. However,

coverage will be delayed until the Group's next Agreement Anniversary Date. In order to verify the coverage election, you and/or your Dependent(s) will be asked to "reapply" for coverage during the Group's Open Enrollment Period. An Open Enrollment Period will be held each year during a period mutually agreed to between the Group and BlueLincs.

TERMINATION OF A DEPENDENT'S COVERAGE

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

ALTERNATE COVERAGE OPTIONS

Some employer groups offer coverage through an Alternate Health Plan. Check with your Campus Benefits Office 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 Campus Benefits Office 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 Campus Benefits Office for eligibility provisions unique to your Group's coverage.

COBRA CONTINUATION COVERAGE

- 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 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 the following, provided the premiums are paid for the coverage as required:

- 18 months from the date of a Qualifying Event involving your termination of employment (other than for reason of gross misconduct) or reduction in working hours; or
- 36 months from the date of a Qualifying Event involving:
 - your death, divorce or legal separation, or your loss of coverage due to becoming entitled to Medicare benefits; or
 - the ineligibility of a Dependent child.

- 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 notify your Employer before the end of the initial 18-month COBRA Continuation Period, and no later than 60 days after the date the Social Security Administration's determination is received. In addition, you or your Eligible Dependent must notify your Employer within 30 days after the Social Security Administration makes a determination that you or your Eligible 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 the first Qualifying Event. This extension is available to the Eligible Dependent only.

CONVERSION PRIVILEGE AFTER TERMINATION OF GROUP COVERAGE

If you stop being a Member 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 at 1-888-881-4648 to request conversion information and an application form.
- Complete the application and **send it directly to BlueLincs within 31 days of the date your Group coverage ended**. 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 your coverage is terminated due to:

- nonpayment of premium by your Employer;
- termination by BlueLincs;
- nonpayment of required Copayments;
- commission of fraud or misrepresentation; or
- termination of the Agreement.

If you relocate and no longer live or work within the BlueLincs Service Area, you may transfer to another plan available through your Employer. If you cease to be an active employee, you may convert to an individual hospital and surgical expense policy issued by an insurance carrier determined by BlueLincs, subject to the same conditions specified above for a BlueLincs individual conversion policy. To apply, contact BlueLincs within 31 days of the date your coverage ends. The individual conversion policy is renewable at the option of the insurance carrier.

WHEN COVERAGE UNDER YOUR PLAN ENDS

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

- When a Member ceases to be an Eligible Dependent by reason of death, coverage for that Member will cease on the date of death.
- Coverage of the Member shall terminate on the date the Member becomes covered under the Employer's Alternate Health Plan (if applicable).
- If you fail to make the required Copayment as specified in your Schedule of Benefits, coverage for you and your Eligible Dependents will terminate 30 days after notice is given to you and the Group, subject to the ***Member Complains & Appeals*** provisions.
- If BlueLincs, after reasonable efforts, is unable to establish and maintain a satisfactory Physician-patient relationship with you or your Eligible Dependents, coverage will end following a 30-day written notice to you, your Eligible Dependents and the Group, subject to the ***Member Complains & Appeals*** provisions.

- In the event you fail to reasonably cooperate with BlueLinics in its right of recovery, determination of workers' compensation coverage, or coordination of benefits efforts, coverage for you and your Eligible Dependents will end after a 30-day notice is sent to you or your Eligible Dependents and the Group, subject to the *Member Complaints & Appeals* provisions.
- A Member's COBRA Continuation Coverage, when applicable, shall cease on the earliest of the following dates:
 - the date the coverage period ends following expiration of the 18-month, 29-month or 36-month 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 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 (including coverage of your Eligible Dependents) will terminate retroactive to your Effective Date if you or the Group commits fraud or material misrepresentation 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.

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 and Dependents will also continue.

Check with the Campus Benefits Office for coverage options available to retired employees and their Dependents.

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 notify the Campus Benefits Office when you move or change your address.

If you are the Subscriber and you move out of the BlueLincs Service Area, it is important that you notify the Campus Benefits Office, as you may no longer be eligible for BlueLincs coverage. You may be eligible for coverage under an Alternate Health Plan provided by your Employer.

CERTIFICATES OF COVERAGE

A Certificate of Coverage will be provided, without charge, for individuals who are or were covered under a Group Health Plan upon the occurrence of any of the following events:

- **Qualified Beneficiaries Upon a Qualifying Event**

In the case of an individual who is a qualified beneficiary entitled to elect COBRA Continuation Coverage, an automatic Certificate of Coverage is required to be provided at the time the individual would lose coverage under the Plan in the absence of COBRA Continuation Coverage or alternative coverage elected instead of COBRA Continuation Coverage.

- **Other Individuals When Coverage Ceases**

In the case of an individual who is not a qualified beneficiary entitled to elect COBRA Continuation Coverage, an automatic Certificate of Coverage is required to be provided at the time the individual ceases to be covered under the Plan.

- **Qualified Beneficiaries When COBRA Ceases**

In the case of an individual who is a qualified beneficiary and has elected COBRA Continuation Coverage (or whose coverage has continued after the individual became entitled to elect COBRA Continuation Coverage), an automatic Certificate of Coverage will be provided at the time the individual's coverage under the Plan ceases.

- **Any Individual Upon Request**

Requests for Certificates of Coverage are permitted to be made by, or on behalf of, an individual within 24 months after coverage ceases.

The Certificate of Coverage gives detailed information about how long you had coverage under the plan. This information may be used to demonstrate "Creditable Coverage" to your new health plan or issuer of an individual health policy. Creditable Coverage may be used to reduce the Preexisting Condition Exclusion period under the new coverage.

BlueLincs has a toll-free telephone number (1-888-881-4648) to assist Members in obtaining Certificates of Coverage and preexisting condition "credit" under another Group Health Plan.

BENEFITS AFTER TERMINATION OF THE AGREEMENT

If the Agreement terminates because BlueLincs ceases to operate, or because BlueLincs elects, for any reason **other than** breach of contract (including default of premium or failure to meet the enrollment requirements for minimum percentage and number of Eligible Persons) to terminate the Agreement, 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
 - 30 days from the date of termination of 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.

Other Coverage and Right of Recoupment

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 applies only if the Member or Dependent has health coverage under more than one plan.

DEFINITIONS

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

- **“Other Agreement”** means any arrangement providing health care benefits or services through:
 - group, blanket or franchise insurance coverage;
 - Blue Cross, Blue Shield, Health Maintenance Organization and other prepayment coverage;
 - coverage under labor-management trusteed plans, union welfare plans, Employer organization plans, or employee benefit organization plans;
 - coverage toward the cost of which any Employer shall have contributed, or with respect to which any Employer shall have made payroll deductions; and
 - coverage under any tax supported or government program to the extent permitted by law.
- **“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 other 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 BlueLines 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 BlueLines 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 the Agreement and Schedule 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;
- 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.

The coverage of any Member who fails to cooperate with BlueLincs in this effort may be terminated under the provisions of the Agreement.

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 RECOURPMENT

- 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.
- Your failure to comply with the above provisions may result in termination of your coverage and/or legal action to enforce collection.

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, or according to any recognized legal remedy arising from an employer-employee relationship. However, BlueLincs and you agree that you will:

- pursue your rights under the workers' compensation laws;

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

You and BlueLincs further agree that BlueLincs may terminate your coverage should you fail to reasonably cooperate and furnish such information and assistance BlueLincs requires to facilitate enforcement of its rights.

If you receive any money in settlement of an employer's liability, regardless of how the settlement is structured or which items of damages are included, you agree 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.

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 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 the Campus Benefits Office 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 Covered Services are rendered for which benefits are payable, and no such action may be taken later than three years after the provision of Covered Services.

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 or Investigational. 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.

BLUECARD PROGRAM

As a BlueLincs Member, you have access to the BlueCard Program **if you require Emergency Care or Urgent Care while traveling outside the BlueLincs Service Area**. Follow-up care following an emergency is also available through the BlueCard Program, provided the services are preauthorized by BlueLincs.

Under BlueCard, when you obtain health care services outside the state of Oklahoma, the amount you pay, if not covered by a flat dollar Copayment, for Covered Services is calculated on the **lower** of:

- the actual billed charges for your Covered Services; or
- the negotiated price that the onsite Blue Cross and/or Blue Shield Licensee (“Host Blue”) passes on to us.

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

Statutes in a small number of states may require the Host Blue to use a basis for calculating Member liability for Covered Services that does not reflect the entire savings realized or expected to be realized on a particular claim or to add a surcharge. Should any state statutes mandate Member liability calculation methods that differ from the usual BlueCard method noted in the above paragraph or require a surcharge, BlueLincs would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

NOTE: BlueLincs may postpone or waive application of your Copayment whenever it is necessary in order to obtain Provider discounts for Covered Services you receive outside the state of Oklahoma.

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

BlueLincs HMO is not the agent of the Member.

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

BLUELINCS/ASSOCIATION RELATIONSHIP

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

QUALITY IMPROVEMENT

BlueLincs has a Quality Improvement Program in place to ensure continuous improvements in the quality of clinical care and the quality of service offered to its Members. BlueLincs annually makes information about the Quality Improvement Program and a report on BlueLincs' progress available. You may request this information by contacting Member Services.

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.

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 Copayments 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 and expenses for noncovered 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), send it to:

BlueLincs HMO
Member Services Department
P. O. Box 3283
Tulsa, Oklahoma 74102-3283

Or you can call 1-888-881-4648.

Please make copies of the itemized bills for your file before you mail 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.

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.***”

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 Member Services Representative. If a resolution cannot be reached in an informal exchange, you may request an administrative review of the problem through the BlueLincs appeal process described below.

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

APPEAL PROCESS (LEVEL I)

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

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

In the case of an appeal involving a non-urgent request or claim, you must submit your request in writing to the following address:

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

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

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

*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. A Provider or other health care professional with knowledge of your medical condition is permitted to act as your authorized representative or to bring an appeal on your behalf.

- In the case of an appeal involving a non-urgent Preauthorization/Precertification request, BlueLincs will provide a written response to you no later than 30 days following the date the appeal is received.
- In the case of an appeal involving a claim other than a non-urgent Preauthorization/Precertification request, BlueLincs will provide a written response to you no later than 60 days following the date the appeal is received.

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

If you and/or your Provider wishes to appeal a Preauthorization/Precertification Request Involving Urgent Care, you and/or your Provider may appeal by contacting Member Services at 1-888-881-4648.

- BlueLincs will respond to you and/or your Provider no later than 72 hours after the appeal request is received.
- BlueLincs' response to a Preauthorization/Precertification Request Involving Urgent Care, including an adverse determination, if applicable, may be issued orally. A written notice will also be provided within three days following the oral notification.

VOLUNTARY RE-REVIEW PROCESS (LEVEL II)

If you are not satisfied with the decision concerning the appeal, you may elect to submit the adverse benefit determination to BlueLincs for re-review. BlueLincs will provide you with information necessary about BlueLincs' voluntary re-review process. To request a re-review of the benefit determination, you should submit the request in writing to the following address:

Member Appeal Coordinator – Member Services Department
BlueLincs HMO
P. O. Box 3283
Tulsa, Oklahoma 741022-3283

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

Within seven working days following BlueLincs' receipt of a voluntary re-review request, you will receive written notification regarding your rights and the time frames for determination.

A Preauthorization/Precertification Request Involving Urgent Care may be re-reviewed by contacting Member Services at 1-888-881-4648.

EXTERNAL REVIEW (LEVEL III)

For services that are denied as not Medically Necessary, medically appropriate or medically effective, Oklahoma law provides the right to an external review by an independent review organization. If requested, BlueLincs will notify you, in writing, of the procedure to obtain an external review as set forth in the Oklahoma Managed Care Review Act.

You are not obligated by the Group Health Plan to pursue BlueLincs' voluntary re-review process or an external review in any specific order. You are not required to exhaust the voluntary re-review process before bringing a civil action. If these review processes do not provide a satisfactory resolution to the claim for benefits, legal remedies are available, including pursuing the claim in court.

Definitions

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.

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 in 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.

BLUECARD

A program which offers access to out-of-town care through Participating Blue Cross and Blue Shield HMOs located across the country. It is intended to supplement the out-of-area coverage that is currently offered.

CALENDAR YEAR

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

CERTIFICATE OF COVERAGE

A document providing information which is intended to enable an individual to establish his/her Creditable Coverage for the purposes of reducing any preexisting condition exclusion imposed on the individual by any subsequent Group Health Plan coverage.

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 Prescription Drug charges for which the Member is responsible.

COPAYMENT

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

COVERED SERVICE

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

CREDITABLE COVERAGE

Coverage provided for you from a wide range of sources, including Group Health Plans, individual health insurance coverage, COBRA Continuation Coverage, Medicare and Medicaid.

CUSTODIAL CARE

Care provided primarily for maintenance of the patient or which is designed essentially to assist the patient in meeting his or her activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness, disease, bodily injury or condition. Custodial Care includes, but is not limited to: help in walking, bathing, dressing, feeding; preparation of special diets; and supervision over self-administration of medications not requiring constant attention of trained medical personnel.

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.

ENROLL

To become covered for benefits under the Agreement (i.e., when coverage becomes effective), without regard to when the individual may have completed or filed any forms that are required in order to Enroll for coverage.

ENROLLMENT DATE

The first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period (typically the date employment begins).

EXPERIMENTAL/INVESTIGATIONAL

A drug, device, biological product, or medical treatment or procedure is Experimental or Investigational 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.

FULL-TIME STUDENT

A person who is regularly attending an accredited secondary school, college or university as:

- an undergraduate student enrolled in 12 or more semester hours, or the academic equivalent; or
- a graduate student enrolled in nine or more semester hours, or the academic equivalent; or
- a graduate assistant student enrolled in six or more semester hours, or the academic equivalent.

GROUP

A number or group of Subscribers who are employed by the Employer, who have been accepted by BlueLines for coverage and whose premiums are remitted to BlueLines 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 BlueLines 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 licensed general Hospital which is listed as a general Hospital by the American Hospital Association or the American Osteopathic Hospital Association and that is primarily engaged in providing diagnostic and therapeutic facilities of the surgical and medical diagnosis, treatment and care of injured and sick persons, by or under the supervision of a staff of Physicians who are duly licensed to practice medicine and surgery, and which continuously provides 24-hour a day nursing services by registered graduate nurses.

HOSPITAL SERVICES

Services for registered bed patients or Outpatients.

INCURRED

An expense is Incurred on the date a Member receives the service or supply for which the charge is made.

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 room and board charge is made.

LATE ENROLLEE

An individual who Enrolls under the Agreement at a time other than during:

- the Initial Enrollment Period; or
- a Special Enrollment Period for the individual.

MEDICAL GROUP

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

MEDICAL GROUP MANAGED CARE COMMITTEE

A group of Medical Group Participating Physicians charged with reviewing the appropriateness and Medical Necessity of health care treatment decisions made by Medical Group Participating Providers.

MEDICAL GROUP NETWORK

The group of Providers (including Physicians, Specialists, Hospitals and other professionals who provide health care services to BlueLines 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)

Services or supplies provided by a Hospital, Physician or other Provider that BlueLincs determines are:

- appropriate for symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury; and
- in accordance with standards of good medical practice; and
- not primarily for the convenience of the Member or the Member's Provider; and
- the most appropriate supply or level of service that can safely be provided to the Member. When applied to hospitalization, this means that the Member requires acute care as a bed patient due to the nature of the services rendered or the Member's condition and the Member cannot receive safe or adequate care as an Outpatient.

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.

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 designated by the Group and agreed to by BlueLincs during which an individual who previously declined coverage may Enroll for coverage under the Agreement as a Late Enrollee.

OUT-OF-POCKET MAXIMUM

The total amount of Copayments to be paid by the Member and the Member's Dependents during a Calendar Year.

- Subscriber Only Coverage. When the Out-of-Pocket Maximum specified in the Schedule of Benefits is reached, no additional Copayments will be required for Covered Services Incurred by the Member during the remainder of the Calendar Year.
- Family Coverage. When each of three Members under the same Family Coverage reaches the Out-of-Pocket Maximum specified in the Schedule of Benefits, no additional Copayments will be required for Covered Services Incurred by any Members under that same Family Coverage during the remainder of the Calendar Year.

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

- Inpatient Mental Services or Alcohol and Drug Abuse Services; or
- Nonauthorized services rendered by a nonparticipating Provider; or
- Prescription Drugs purchased at a retail pharmacy; or
- Self-Referral Services; 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 PROVIDER (PHYSICIAN, SPECIALIST, HOSPITAL, HOME HEALTH CARE AGENCY, PHARMACY, SKILLED NURSING FACILITY, OTHER HEALTH CARE PROFESSIONALS, ETC.)

Any Provider of health care services 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 a Participating Pharmacy Agreement with BlueLincs.

PARTICIPATING SPECIALTY PHARMACY

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

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/PRECERTIFICATION

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

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 anti-anxiety effects.

PRESCRIPTION ORDER

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

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 BlueLines 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 BlueLines 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 BlueLines.

PROVIDER

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

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.

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 BlueLines is licensed by the Oklahoma Insurance Department to provide health care services. A Member may call the BlueLines Member Services Department at 1-888-881-4648 to determine if he or she is in the Service Area or log on to the Web site at www.bcbsok.com.

SKILLED 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.

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 meet at least two of the following criteria:

- they are high cost;
- they are for use in limited patient populations or indications;
- they are typically self-injected;
- they have limited availability, require special dispensing, or delivery and/or patient support is required and, therefore, they are difficult to obtain via traditional Pharmacy channels;
- complex reimbursement procedures are required; and/or

- a considerable portion of the use and costs are frequently generated through office-based medical claims.

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.



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BlueLincs HMO is a subsidiary of Health Care Service Corporation,
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