BlueCross BlueShield of Oklahoma







Your Health Care Benefits Program

Blue Cross and Blue Shield of Oklahoma, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Blue Balance Funded

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Provider Directory	www.bcbsok.com
Prescription Drug List	www.bcbsok.com www.bcbsok.com/prescription-drugs/managing-prescriptions/drug-lists
Prior Authorization List	www.bcbsok.com
Preventive Services	https://www.bcbsok.com/provider/clinical/clinical-resources/preventive-care
• Customer Service • Prior Authorization • Inpatient Admissions • Appeals • Claim Forms • Prescription Drug • Mail-Order Services • Pharmacy Locator	See **CUSTOMER SERVICE** section in this benefit booklet for contact information such as phone numbers, websites and mailing addresses where available
Definitions	See **GLOSSARY** section. Defined terms are in bold in your booklet
Your cost share information for **covered services**	See SUMMARY OF BENEFITS section. Cost shares for medical and **pharmacy** services are listed separately in this section.

CUSTOMER SERVICE

Medical Benefits	Call	Website
Customer Service Helpline	See telephone number on the back of your identification card.	www.bcbsok.com BCBSOK Provider Directory Wellness Other Online Services and Information
Prior authorization (for Non-Behavioral Health) (for Behavioral Health)	See telephone number on the back of your identification card.	
INPATIENT ADMISSIONS (for Non-Behavioral Health) (for Behavioral Health)	See telephone number on the back of your identification card.	

Self-Service Member Portal Blue Access For Members (BAM)	Website
Provider Directory, Identification Card, Claims	www.bcbsok.com

For Medical Appeals Send via mail	Mailing Address:
(for Behavioral Health/Mental Health/Substance Use Disorder Treatment, and Non-Behavioral Health)	Blue Cross and Blue Shield of Oklahoma Appeals Division PO Box 655924 Dallas, TX 75265-5924

BLUECARD® NATIONWIDE/WORLDWIDE COVERAGE PROGRAM
1-800-810-BLUE (2583) – http://provider.bcbs.com

MDLIVE®
1-888-684-4233

Prescription Drug Benefits	Call	Website
Pharmacy Benefit Manager (PBM) Prime Therapeutics Claim Forms and Pharmacy Locator	See telephone number on the back of your identification card	www.bcbsok.com

Where to Mail Completed Claim Forms:

For Medical Claims	Prescription Drug Claims
Blue Cross Blue Shield of Oklahoma Attn: Claims Review Department. PO Box 655924 Dallas, TX 75265-5924	Prime Therapeutics LLC PO Box 25136 Lehigh Valley, PA 18002-5136

SUMMARY OF MEDICAL BENEFITS

This is your **SUMMARY OF BENEFITS**. It shows your cost share including **deductible** amounts, **copayment** amounts and **coinsurance** amounts and how they apply to the **covered services** you receive under this **plan**. The information below summarizes your cost share and any limits that may apply to **covered services**. You may contact Customer Service at the telephone number on the back of your member **identification card** for any questions or additional information.

To receive maximum **benefits** under the **plan**, you must receive services from Blue Options **providers** in Oklahoma or BlueCard **providers** outside the state of Oklahoma. These are your **in-network providers**. You will receive the highest level of **benefits** if you use Blue Options **providers** whenever possible.

How cost sharing works:

- The **deductible** amounts and **copayment** amounts listed in the charts below show the amounts you pay for **covered services**.
- **Coinsurance** amounts, if any, listed in the charts below are the percentage of the **allowable amount** you pay. You may have to satisfy **deductible** amount(s), **copayment** amount(s) and/or **coinsurance** amount(s) before you receive services.
- All **copayment** and **coinsurance** costs shown in the charts below are after your **deductible** has been met, if a **deductible** applies.
- Your **benefit period** is a period of one year beginning on January 1st of each year. When you first enroll under this **plan**, your coverage begins on the date shown above and ends on the first day of the month the following year. For example 12/01/2025 - 12/01/2026.

Benefit Period	Calendar year		
Deductible	**Blue Preferred or BlueCard PPO Provider You Pay**	**Blue Choice Provider You Pay**	**Out-of-Network You Pay**
Individual	$3,400	$3,400	$5,000
Family	$6,800	$6,800	$10,000
• In and out-of-network deductibles amounts will be applied to each other			

Out-of-Pocket Maximum	**Blue Preferred or BlueCard PPO Provider You Pay**	**Blue Choice Provider You Pay**	**Out-of-Network You Pay**
Individual	$5,000	$5,700	$15,000
Family	$10,000	$11,400	$30,000
• Copays are not usually subject to deductible, but always applied to out-of-pocket maximums. • If a single-family member reaches the individual out-of-pocket maximum then coinsurance will apply and they do not have to wait for other members to meet their out-of-pocket maximum			

Ambulance Services

Description	Blue Preferred or BlueCard PPO Provider You Pay	Blue Choice Provider You Pay	Out-of-Network You Pay
Air Ambulance	10% coinsurance after calendar year deductible	10% coinsurance after calendar year deductible	10% coinsurance after calendar year deductible
Ground Ambulance	10% coinsurance after calendar year deductible	10% coinsurance after calendar year deductible	10% coinsurance after calendar year deductible

Autism Spectrum Disorder

Description	Blue Preferred or BlueCard PPO Provider You Pay	Blue Choice Provider You Pay	Out-of-Network You Pay
Autism Spectrum Disorder	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

- Physical therapy, occupational therapy, and speech therapy visits related to treatment of autism spectrum disorder are not subject to the limitations specified under each therapy in this SUMMARY OF BENEFITS.

Behavioral Health Services (Mental Health/Substance Use Disorder)

Description	Blue Preferred or BlueCard PPO Provider You Pay	Blue Choice Provider You Pay	Out-of-Network You Pay
Mental Health Services	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Substance Use Disorder	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Chiropractic Care

Description	Blue Preferred or BlueCard PPO Provider You Pay	Blue Choice Provider You Pay	Out-of-Network You Pay
Chiropractic Treatment	10% coinsurance after calendar year deductible	20% coinsurance after calendar year deductible	40% coinsurance after calendar year deductible
Limits	25 visit maximum per benefit period (Combined with Outpatient Therapy)		

Dental Services for Accidental Injury

Description	Blue Preferred or BlueCard PPO Provider You Pay	Blue Choice Provider You Pay	Out-of-Network You Pay
Office Visit	10% coinsurance after calendar year deductible	20% coinsurance after calendar year deductible	40% coinsurance after calendar year deductible

Durable Medical Equipment (DME)

Description	Blue Preferred or BlueCard PPO Provider You Pay	Blue Choice Provider You Pay	Out-of-Network You Pay
DME	10% coinsurance after calendar year deductible	20% coinsurance after calendar year deductible	40% coinsurance after calendar year deductible

Emergency Services

Description	Blue Preferred or BlueCard PPO Provider You Pay	Blue Choice Provider You Pay	Out-of-Network You Pay
Emergency Care Facility Charges	10% coinsurance after calendar year deductible	10% coinsurance after calendar year deductible	10% coinsurance after calendar year deductible
Emergency Care Physician Charges	10% Coinsurance after calendar year deductible	10% coinsurance after calendar year deductible	10% Coinsurance after calendar year deductible

Fertility Services

Description	Blue Preferred or BlueCard PPO Provider You Pay	Blue Choice Provider You Pay	Out-of-Network You Pay
Fertility Treatments	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Gender Affirming Care

Description	Blue Preferred or BlueCard PPO Provider You Pay	Blue Choice Provider You Pay	Out-of-Network You Pay
Gender Reassignment Surgery	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Hearing Aids and Audiological Services

Description	Blue Preferred or BlueCard PPO Provider You Pay	Blue Choice Provider You Pay	Out-of-Network You Pay

Services to restore loss of or correct an impaired speech or hearing function with hearing aids	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received
Hearing Aids	10% coinsurance after calendar year deductible	20% coinsurance after calendar year deductible	40% coinsurance after calendar year deductible
Limits	One hearing aid per every 48 months, and up to four additional ear molds per benefit period, if medically necessary		

Home Health Care

Description	Blue Preferred or BlueCard PPO Provider You Pay	Blue Choice Provider You Pay	Out-of-Network You Pay
Home Health Care	10% coinsurance after calendar year deductible	20% coinsurance after calendar year deductible	40% coinsurance after calendar year deductible

Hospice Care

Description	Blue Preferred or BlueCard PPO Provider You Pay	Blue Choice Provider You Pay	Out-of-Network You Pay
Hospice Services	10% coinsurance after calendar year deductible	20% coinsurance after calendar year deductible	40% coinsurance after calendar year deductible
• Hospice care that is provided in a hospital will include charges as described in the **COVERED SERVICES** section of your benefit booklet			

Infusion Therapy

Description	Blue Preferred or BlueCard PPO Provider You Pay	Blue Choice Provider You Pay	Out-of-Network You Pay
Infusion Therapy performed in the home, office or infusion suite	10% coinsurance after calendar year deductible	20% Coinsurance after calendar year deductible	40% Coinsurance after calendar year deductible

Outpatient Infusion Therapy performed in hospital setting	10% Coinsurance after calendar year deductible	20% Coinsurance after calendar year deductible	40% Coinsurance after calendar year deductible
• NOTE: Outpatient Infusion Site of Care does NOT apply to H S A products/plans. • Copay does not apply for non-maintenance drugs. • Infusion therapy for non-maintenance drugs is subject to the benefit period deductible, copay, and or coinsurance.			

Inpatient Hospital Services

Description	Blue Preferred or BlueCard PPO Provider You Pay	Blue Choice Provider You Pay	Out-of-Network You Pay
Inpatient Facility Services	10% coinsurance after calendar year deductible	20% coinsurance after calendar year deductible	40% coinsurance after calendar year deductible
Inpatient Physician Services	10% coinsurance after calendar year deductible	20% coinsurance after calendar year deductible	40% coinsurance after calendar year deductible
• Certain services will require **prior authorization** • All usual hospital services and supplies, including semiprivate room, intensive care, and coronary care units • Includes treatment of **behavioral health services**			

Maternity Services

Description	Blue Preferred or BlueCard PPO Provider You Pay	Blue Choice Provider You Pay	Out-of-Network You Pay
Maternity Care	10% coinsurance after calendar year deductible	20% coinsurance after calendar year deductible	40% coinsurance after calendar year deductible
Maternity Related Newborn Care	10% coinsurance after calendar year deductible	20% coinsurance after calendar year deductible	40% coinsurance after calendar year deductible
Prior Authorization	Inpatient prior authorization not required for the following length of stays: 48 hours following an uncomplicated vaginal delivery 96 hours following an uncomplicated delivery by caesarean section		

Occupational Therapy Services

Description	Blue Preferred or BlueCard PPO Provider	Blue Choice Provider You Pay	Out-of-Network You Pay
Occupational Therapy	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Orthopedics/Orthotic Devices

Description	Blue Preferred or BlueCard PPO Provider	Blue Choice Provider You Pay	Out-of-Network You Pay
Orthopedic/orthotic devices	10% after calendar year deductible	20% after calendar year deductible	40% after calendar year deductible

Outpatient Hospital Services

Description	Blue Preferred or BlueCard PPO Provider You Pay	Blue Choice Provider You Pay	Out-of-Network You Pay
Outpatient Facility Services	10% coinsurance after calendar year deductible	20% coinsurance after calendar year deductible	40% coinsurance after calendar year deductible
Outpatient Physician Services	10% coinsurance after calendar year deductible	20% Coinsurance after calendar year deductible	40% Coinsurance after calendar year deductible
Outpatient Diagnostic Imaging Services	10% Coinsurance after calendar year deductible	20% Coinsurance after calendar year deductible	40% Coinsurance after calendar year deductible

- Certain services will require prior authorization.
- Includes lab & x-ray, including certain diagnostic procedures.

Pharmacy Services

For information on prescription drugs benefit and cost share please refer to your **SUMMARY OF BENEFITS FOR PHARMACY BENEFITS** directly following this **SUMMARY OF BENEFITS**

Physical Therapy Services

Description	Blue Preferred or BlueCard PPO Provider	Blue Choice Provider You Pay	Out-of-Network You Pay
Physical Therapy In the Office	10% Coinsurance after calendar year deductible	20% Coinsurance after calendar year deductible	40% Coinsurance after calendar year deductible
Physical Therapy In an Outpatient Setting	10% Coinsurance after calendar year deductible	20% Coinsurance after calendar year deductible	40% Coinsurance after calendar year deductible

Physician and Specialist Services

Description	Blue Preferred or BlueCard PPO Provider You Pay	Blue Choice Provider You Pay	Out-of-Network You Pay
Primary Care Office Visit	10% Coinsurance after calendar year	20% Coinsurance after calendar year deductible	40% Coinsurance after calendar year deductible
Specialty (Specialist) Office Visit	10% Coinsurance after calendar year	20% Coinsurance after calendar year deductible	40% Coinsurance after calendar year deductible
Telemedicine Services	10% Coinsurance after calendar year	20% Coinsurance after calendar year deductible	40% Coinsurance after calendar year deductible

- Includes treatment of **behavioral health services**.
- Cost shares for **covered services** provided through **telemedicine** visits will be the same as if provided in-person, except where otherwise noted**.**

Preventive Care Services

Description	Blue Preferred or BlueCard PPO Provider You Pay	Blue Choice Provider You Pay	Out-of-Network You Pay
Annual Mammography Screening	No charge	No charge	No charge
Covered Childhood Immunizations	No charge	No charge	No charge
Other Preventive Care Services	No charge	No charge	30% Coinsurance after calendar year deductible

Note: **Preventive care services** are paid at 100% of the **allowable charge** and not subject to **deductibles, copayments**, and/or **coinsurance** if services are received from **network providers**.

Private Duty Nursing

Description	Blue Preferred or BlueCard PPO Provider You Pay	Blue Choice Provider You Pay	Out-of-Network You Pay
Private Duty Nursing	10% coinsurance after calendar year deductible	20% coinsurance after calendar year deductible	40% coinsurance after calendar year deductible
Limits	Up to 85 day maximum per benefit period		

Skilled Nursing Facility

Description	Blue Preferred or BlueCard PPO Provider You Pay	Blue Choice Provider You Pay	Out-of-Network You Pay
Skilled Nursing Facility	10% coinsurance after calendar year deductible	20% coinsurance after calendar year deductible	40% coinsurance after calendar year deductible
Limits	30 day maximum per benefit period		

Speech Therapy

Description	Blue Preferred or BlueCard PPO Provider	Blue Choice Provider You Pay	Out-of-Network You Pay
Speech Therapy	Covered based on type of service and where it is received	Covered based on type of service and where it is received	Covered based on type of service and where it is received

Surgery

Description	Blue Preferred or BlueCard PPO Provider	Blue Choice Provider You Pay	Out-of-Network You Pay
Surgical/Medical Services Office Visit	10% coinsurance after calendar year deductible	20% coinsurance after calendar year deductible	40% coinsurance after calendar year deductible
All Other Covered Surgical/Medical Services	10% coinsurance after calendar year deductible	20% coinsurance after calendar year deductible	40% coinsurance after calendar year deductible

Transplant Services (Organ and Tissue Transplants)

Description	Blue Preferred or BlueCard PPO Provider	Blue Choice Provider You Pay	Out-of-Network You Pay
Organ and Tissue Transplants	10% coinsurance after calendar year deductible	20% coinsurance after calendar year deductible	40% coinsurance after calendar year deductible

Urgent Care

Description	Blue Preferred or BlueCard PPO Provider	Blue Choice Provider You Pay	Out-of-Network You Pay
Urgent Care Center Visit	10% coinsurance after calendar year deductible	20% coinsurance after calendar year deductible	40% coinsurance after calendar year deductible

Wigs

Description	Blue Preferred or BlueCard PPO Provider	Blue Choice Provider You Pay	Out-of-Network You Pay
Wigs or Other Scalp Prostheses	10% coinsurance after calendar year deductible	20% coinsurance after calendar year deductible	40% coinsurance after calendar year deductible
Limits	Limited to 2 wigs per benefit period		

SUMMARY OF PHARMACY BENEFITS

This is your summary of benefits for prescription drugs. It shows your cost share including **deductible amounts, copayment amounts** and **coinsurance amounts** and how they apply to the **covered prescription drugs** you receive under this **plan**. The information below summarizes your cost share and any limits that may apply to prescription drugs. You may contact Customer Service at the telephone number on the back of your member **identification card** or access your self-service online member portal, Blue Access for Members℠ (BAM) for any questions or additional information regarding your benefits or prescription **drug list**.

The **PHARMACY BENEFITS** section of this **benefit booklet** includes details on how the following **pharmacy benefits** work:

- Pharmacy **out-of-pocket maximums**
- How **copayment** and/**coinsurance** amounts apply
- **Prior authorizations**

Benefit Period	Calendar Year

Out-of-Pocket Maximum

Pharmacy Out-of-Pocket Maximum	**In-Network Providers**	**Out-of-Network Providers**
Individual	$5,000	$15,000
Family	$10,000	$30,000

Any difference between the allowable charge of a brand name drug and the allowable charge of a generic drug for which you are responsible does apply to the deductible or out-of-pocket maximum.

Any deductible, copayment and/ or coinsurance amounts for prescription orders filled at a participating pharmacy or specialty in-network pharmacy will apply to your benefit period deductible and out-of-pocket maximum for in-network provider services

When prescription orders are filled at an out-of-network pharmacy, the following provisions apply:

- You are responsible for a percentage of allowable charges, plus the applicable copayment or coinsurance shown below. ; and
- In addition to your copayment and/or coinsurance amounts, you will be responsible for the cost difference, if any, between the pharmacy's billed charges and the allowable charge determined by us.

You may not be required to pay the difference in cost between the allowable charge of the brand name drug and the allowable charge of the generic drug if there is both:

- A medical reason (e.g., adverse event) you need to take the brand name drug
- Certain criteria are met

Your provider can submit a request to waive the difference in cost between the allowable charge of the brand name drug and allowable charge of the generic drug. In order for this request to be reviewed:

- Your physician or other provider must send in a MedWatch form to the Food and Drug Administration (FDA) to let them know the issues you experienced with the generic equivalent.
- Your physician **or other provider** must provide a copy of this form when requesting the waiver.

The FDA MedWatch form is used to document adverse events, therapeutic inequivalence/failure, product quality problems, and product use/medication error. This form is available on the FDA website. If the waiver is granted, applicable copayment and/or coinsurance amounts will still apply. For additional information, contact Customer Service at the number on the back of your identification card or visit www.bcbsok.com.

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

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

Retail Pharmacy Cost Share

Retail Pharmacy Program (Up to a 30-Day Supply)	Preferred Participating Pharmacy You pay	Participating Pharmacy You pay	Out-of-Network Retail Pharmacy You pay
Tier 1	10% of allowable charges	20% of allowable charges	20% coinsruance plus 50%of allowable charges
Tier 2	10% of allowable charges	20% of allowable charges	20% coinsurance plus 50%of allowable charges
Tier 3	20% of allowable charges	30% of allowable charges	30% coinsurance plus 50%of allowable charges
Tier 4	30% of allowable charges	40% of allowable charges	40% coinsurance plus 50%of allowable charges

Extended Prescription Drug Supply Program

Extended Prescription Drug Supply Program	Quantity Dispensed	Participating Extended Supply Pharmacy You pay	Out-of-Network Extended Supply Pharmacy You pay
Tier 1	1 to 90 days	10% of allowable charges	Not covered
Tier 2	1 to 30 days	10% of allowable charges	Not covered
	31 to 60 days	10% of allowable charges	Not covered
	61 to 90 days	10% of allowable charges	Not covered
Tier 3	1 to 30 days	20% of allowable charges	Not covered
	31 to 60 days	20% of allowable charges	Not covered
	61 to 90 days	20% of allowable charges	Not covered
Tier 4	1 to 30 days	30% of allowable charges	Not covered
	31 to 60 days	30% of allowable charges	Not covered
	61 to 90 days	30% of allowable charges	Not covered

Mail-Order Pharmacy Program

Mail Order Pharmacy Program	Quantity Dispensed	Participating Mail-Order Pharmacy	Any Pharmacy Other Than The Participating Mail-Order Pharmacy
Tier 1	1 to 90 days	10% of allowable charges	Not covered
Tier 2	1 to 30 days	10% of allowable charges	Not covered
	31 to 60 days	10% of allowable charges	Not covered
	61 to 90 days	10% of allowable charges	Not covered
Tier 3	1 to 30 days	20% of allowable charges	Not covered
	31 to 60 days	20% of allowable charges	Not covered
	61 to 90 days	20% of allowable charges	Not covered

Tier 4	1 to 30 days	30% of allowable charges	Not covered
	31 to 60 days	30% of allowable charges	Not covered
	61 to 90 days	30% of allowable charges	Not covered

Specialty Pharmacy Program

Specialty Pharmacy Program (30-Day Supply)	Specialty Network Pharmacy	Other Pharmacy You Pay
Tier 5	40% of allowable charges	40% Coinsurance plus 50% of allowable charges
Tier 6	50% of allowable charges	50% coinsurance plus 50% of allowable charges

- In addition to any copayments and/or coinsurance amounts, you are also responsible for any charges which exceed the allowable amounts
- 30-day supply
- One copayment amount per 30-day supply – limited to a 30-day supply

Some specialty drugs have FDA approved dosing regimens exceeding the 30-day supply limits and may be allowed greater than a 30-day supply, if allowed by your plan benefits. Cost share will be based on a day supply (1-30-day supply, 31-60-day supply, 61-90-day supply) dispensed.

Vaccines

Select Vaccines Obtained through Pharmacies	Pharmacy Vaccine Network Pharmacy You pay	Other Pharmacy You pay
	Covered vaccine(s) - $0 Copay	Not covered

- Each participating pharmacy that has contracted with BCBSOK to provide this service may have age, scheduling, or other requirements that will apply, so you are encouraged to contact them in advance. Childhood immunizations subject to state regulations are not available under this pharmacy benefit. Refer to your BCBSOK medical coverage for benefits available for childhood immunizations

PLAN SUMMARY

The **employer** has established and maintains a self-insured **plan** of comprehensive health care **benefits** (called the ***plan***) for its eligible **employee**s and other persons as designated in its personnel policy.

The **plan** is operated under an Administrative Services Agreement between the **employer** and Blue Cross and Blue Shield of Oklahoma, a division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association, (called the **claims administrator**).

Under this Agreement we provide **benefits** on behalf of the **employe**r in accordance with the terms of the **plan** and performs certain other services on behalf of the **employer.** The **employer** reserves the right to amend or cancel any or all provisions of the **plan** at any time as it relates to any **covered person**.

We provide administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

This benefit booklet is issued according to the terms of the **plan**. It is not a summary **plan** description. It is only a summary of **benefits**, and all statements in this benefit booklet are subject to the terms of the **plan** documents on file in your Human Resources Department.

This benefit booklet replaces any and all summaries, certificates or benefit booklets previously issued for the **employees** under the **plan.** It describes the **plan** in effect as of the date agreed upon between the **employer** and us for all **covered persons** (called “you” or “your”).

INTRODUCTION

This is your health insurance benefit booklet. It describes your **covered services**, what they are and how you obtain them.

The defined terms throughout this booklet are in bold font and are defined in the **GLOSSARY** or defined within the applicable section when used only the one time.

The terms "you", "your", "**participant**" and "**member**" are used in this benefit booklet in reference to the **employee** or subscriber, as applicable.

The term "us", "we", and "our" is used to describe the BlueCross and BlueShield (BCBS) **plan** that is the **claim administrator.**

In-Network Benefits

To receive **in-network benefits** as shown under your **SUMMARY OF BENEFITS (SOB)**, you must choose **providers** within the **network** of your plan (except for emergencies). We have established a **network** of **physicians**, **providers**, **specialists**, **hospitals**, and other health care facilities that may offer care and **covered services** to you and your **dependents.** They are listed in our **provider** directory. For help in finding an **in-network provider** you can view our **provider** directory by visiting our website at www.bcbsok.com.

When you choose an **in-network provider**, the **provider** will bill us, not you, for services provided.

Out-of-Network Benefits

If you choose an **out-of-network provider**, only **out-of-network benefits** will be available (except for emergencies or any other covered benefit required by state or federal law to be covered as in-network). If you go to a **provider** outside the **network,** then **benefits** will be paid at the **out-of-network** benefit level. You may have to pay in full and then submit a claim to us for reimbursement.

Your Insurance Identification Card

We will mail you your **identification card**. Show your **identification card** each time you receive services from a **provider**. If you haven't received it before you need **covered services**, or if you lose it, you can print a temporary card on the member website at www.bcbsok.com/member. Only covered **dependents** on your **plan** can use your **identification card**. Duplicate cards can be requested for each covered **member** of your family.

About Your Summary of Benefits

Your **SUMMARY OF BENEFITS** shows the out-of-pocket costs you are responsible for when you receive **covered services.** It may also show benefit limitations or other useful information that apply to your **plan**.

Out-of-pocket costs include things like **deductibles**, **copayments,** and **coinsurance**. Limitations include things like maximum age, visits, days, hours, and admissions.

Your **SUMMARY OF BENEFITS** will also show any total maximum **out-of-pocket limit(s**) that may apply.
You are responsible for paying your part of the cost sharing. You are also responsible for costs not covered by us.

See **HOW THE PLAN WORKS** below and your **SUMMARY OF BENEFITS** for more information.

What Medical Necessity/Medically Necessary Means

You will see the terms **medical necessity** or **medically necessary** in your benefit booklet. The **GLOSSARY** defines it but resources like **CUSTOMER SERVICE** or Blue Access for Members℠ (BAM) can get help with questions on whether specific services meet the requirements to be considered **medically necessary** or meet **medical necessity**.

WHO GETS BENEFITS

No separate eligibility rules or variations in premium will be imposed based on any **health status related factor**. **Benefits** under this **plan** are provided regardless of your race, color, national origin, sex, age, disability, or other status protected by applicable law. Variations in the administration, processes or **benefits** provided under the **plan** that are based on clinically indicated, reasonable medical management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute prohibited discrimination.

Eligibility Requirements

The eligibility date is the date you or your **dependents** qualify to be covered under this **plan**. You qualify for coverage under this benefit booklet when you satisfy the following:

- Meet the definition of an eligible person as specified by your **employer.**
- Have applied for this coverage.
- Have received a BCBSOK insurance **identification card.**

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

If you apply for coverage, you may include your **dependents**. Eligible **dependents** are:

- Your spouse.
- Your **domestic partner** (Note: **domestic partner** coverage is available at your **employer's** discretion. Contact your **employer** for information on whether **domestic partner** coverage is available for your **group**).
- Your **child** until the month they turn age 26.
- A **child** such as a step**child**, an eligible foster **child**, an adopted **child** or **child** placed for adoption (including a **child** for whom you, your spouse (provided your **plan** covers **domestic partnership**),or your **domestic partner** is a party in a legal action in which the adoption of the **child** is sought), under 26 years of age.
- A **child** who is medically certified as **disabled** and **dependent** upon you, your spouse (or **domestic partner**) is eligible to continue coverage beyond age 26, provided the disability began before the **child** turned age 26.

Note: Civil union and domestic partnership coverage is available at your **employer's** discretion. Contact your **employer** for information on whether **civil union** or **domestic partner** coverage is available under your **plan**.

Applying For Coverage

You and your eligible **dependents** can apply for coverage during the following time periods by contacting your **employer**:

- During the open enrollment period.
- At special enrollment periods during the year.

Open Enrollment Period

Your **group** will designate an **open enrollment period** during which you may apply for or change coverage for you and your eligible **dependents**.

Special Enrollment Period

You may apply for or change coverage for yourself and your eligible **dependents** during the following qualifying events:

- You or your **dependen**t lose other health insurance coverage or **COBRA continuation coverage.**
- You gain a **dependent** through marriage, establishment of a **domestic partnership** or court ordered coverage.
- You gain a **dependent** through birth, adoption or placement for adoption, legal guardianship or placement of a foster **child.**
- You or your **dependent** lose eligibility for coverage under a Medicaid **plan** or a state **child** health **plan** under Title XXI of the Social Security Act.
- You or your **dependent** become eligible for assistance under a Medicaid **plan** or a state **child** health **plan**.

Other Special Enrollment Periods

You may apply for or change coverage for yourself and your eligible **dependents** during the following qualifying events:

- You get a divorce (or end a **domestic partnership).**
- The month your **child** reaches 26 years of age.
- You or any of your **dependents** die.
- You lose coverage under your **plan** as specified under the **Termination of Coverage** section of this benefit booklet.
- You are ordered by a court to provide coverage to an eligible **dependent** under your plan.
    - You must provide the court order along with your application to add the **dependent** within 31 days after issuance of the court order.

Employee Application / Change Form

You can obtain an **employee** application / change form from your **employer**, by calling the number on your **identification card** or by accessing your self-service member portal, Blue Access for Members℠ (BAM) for the qualifying events listed above in addition to:

- Updating you and your **dependents'** name.
- Updating you and your **dependents'** address.
- Cancel all or a portion of your coverage.

An address change may result in benefit changes for you and your **dependents** if you move out of the **service area** of the **network**.

Late Enrollment

If your application is not received within 31 days from the eligibility date, you will be considered a **late enrollee**. You will become eligible to apply for coverage during your **employer**'s next **open enrollment period**. Your coverage will become effective on the **contract date**.

When Coverage Begins

The **effective date** is the date coverage begins. It may be different from the eligibility date.

Dependent Special Enrollment Coverage

Coverage begins from the date of event if you apply for this change within 31 days of any of the following qualifying events:

- You gain a **dependent** through marriage, establishment of a **domestic partnership** or court ordered coverage.

However, if a court has ordered you to provide coverage, the **effective date** will be determined by the **plan** in accordance with the provisions of the court order following the date the application for coverage is received.

Coverage is automatic for the first 31 days for the following qualifying events. For coverage to continue beyond this time, you must apply for this change within the 31 day period:

- You gain a **dependent** through birth.
- Adoption or placement for adoption
- Legal guardianship or placement of a foster **child.**

Medicaid or Child Health Plan Special Enrollment Coverage

Coverage begins no later than the first of the month if you apply within 60 days of the following qualifying event:

- You or your **dependent** lose eligibility for coverage under a Medicaid **plan** or a state **child** health **plan** under Title XXI of the Social Security Act.
- You or your **dependent** become eligible for assistance under such Medicaid **plan** or state **child** health **plan.**

Loss of Other Health Insurance Special Enrollment Coverage

Coverage begins no later than the first of the month after the **plan** receives your application for enrollment for yourself or on behalf of your **dependent**(s) if you apply within 31 days of any of the following qualifying events:

- You or your **dependent** lose other health insurance coverage or **COBRA continuation coverage**

The special enrollment period for loss of other health insurance coverage is available to you and your **dependent** who meet the following requirements:

- You and your **dependent** were covered under other health insurance coverage or **COBRA continuation coverage** when you were first eligible to enroll for this coverage
- You and your **dependent** lost the other health insurance coverage due to:
    - Legal separation
    - Divorce or the end of a domestic partnership

    - Death of a spouse, or domestic partner
    - Termination of employment or reduction of hours
    - **COBRA continuation coverage** is terminated as explained under **COBRA Continuation Coverage** in this section of the benefit booklet
- You and your **dependent** did not lose coverage due to failure to pay premiums or for cause (such as a fraudulent claim or an intentional misrepresentation of a material fact in connection with the **plan**).
- If it was required, you stated in writing that you and your **dependent** were covered by other health insurance or **COBRA continuation coverage** as reason for declining enrollment in this coverage.

COBRA Continuation Coverage

This provision may not apply to your group's coverage. Please check with your group administrator to determine if your group is subject to COBRA regulations.

Eligibility for Continuation Coverage

When a **qualifying event** occurs, eligibility under this Certificate may continue for you and/or your eligible **dependents** (including your widow/widower, your divorced or legally separated spouse, and your children) who were covered on the date of the qualifying event. A **child** who is born to you, or placed for adoption with you, during the period of **COBRA continuation coverage** is also eligible to elect **COBRA continuation coverage**.

You or your eligible **dependent** is responsible for notifying the **employer** within 60 days of the occurrence of any of the following events:

- Your divorce or legal separation; or
- Your **dependent child** ceasing to be an eligible **dependent** under the plan; or
- The birth, adoption or placement for adoption of a **child** while you are covered under **COBRA continuation coverage**.

A domestic partner is not recognized as a spouse for certain federally regulated programs, such as COBRA Continuation Coverage and Medicare.

Election of Continuation Coverage

You or your eligible **dependent** must elect **COBRA continuation coverage** within 60 days after the later to occur of:

- The date the **qualifying event** would cause you or your **dependent** to lose coverage; or
- The date your **employer** notifies you, or your eligible **dependent**, of your **COBRA continuation coverage** rights.

COBRA Continuation Coverage Period

You and/or your eligible **dependents** are eligible for coverage to continue under your **group's** coverage for a period not to exceed:

- 18 months from the date of a loss in coverage resulting from a **qualifying event** involving your termination of employment or reduction in working hours; or
- 36 months from the date of a loss in coverage resulting from a **qualifying event** involving:
    - your death, divorce or legal separation, or your loss of coverage due to becoming entitled to Medicare; or
    - the ineligibility of a **dependent child**;

  provided the premiums are paid for the coverage as required.

Disability Extension

- **COBRA continuation coverage** may be extended from 18 months to 29 months for you or an eligible **dependent** who is determined by the Social Security Administration to have been **disabled** on the date of a qualifying event, or within the first 60 days of **COBRA continuation coverage.**
    - This 11-month disability extension is also available to nondisabled family members who are entitled to **COBRA continuation coverage**.
- To request the 11-month disability extension, you or your **dependent** must give notice of the disability determination to the **employer** before the end of the initial 18-month **COBRA continuation coverage** period, and no later than 60 days after the date of the Social Security Administration's determination.
    - In addition, you or your **dependent** must notify the **employer** within 30 days after the Social Security Administration makes a determination that you or your **dependent** is no longer **disabled**.

Multiple Qualifying Events

In the event an eligible **dependent** experiences a second **qualifying event** after onset of **COBRA continuation coverage** resulting from your termination or reduction in work hours, the maximum period of coverage is 36 months from the date of a loss in coverage resulting from the first qualifying event. This extension is available to the eligible **dependent** only.

Special TAA/ATAA Election Period

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

HOW THE PLAN WORKS

Your **SUMMARY OF BENEFITS** lists what you pay for each type of **covered service**. In general, this is how your **benefits** work:

- You pay the deductible when it applies. Then we, the **plan** and you, the **participant**, share the expense. Your share is called a **copayment** or a **coinsurance** amount.
- Then we, the **plan**, pay the entire expense after you reach your **out-of-pocket maximum**.
- Expenses in this general rule means the **allowable amount** for services received from an **in-network provider** and **out-of-network provider**.
    - You have an in-network **deductible** and an out-of-network **deductible**
    - You have an in-network **out-of-pocket** maximum and an out-of-network **out-of-pocket**

If you pay for medically necessary covered services and do not use your insurance, you may still be able to receive credit towards your in-network or out-of-network deductible, and/or your in-network or out-of-network out-of-pocket maximum if:

- Your **provider** does not submit a claim to us;
- The amount you paid your **provider** is less than the average **allowed amount** that the **plan** pays for that **covered service**; and
- You submit a completed claim form with an itemized receipt and proof of payment. Please visit www.bcbsok.com for more information

Allowable Amount

The **allowable amount** is the maximum amount of **benefits** we will pay for expenses you incur under the **plan**. We have established an **allowable amount** for:

- **Medically necessary** services, supplies, and procedures provided by **in-network providers** that have contracted with us or any other Blue Cross and/or Blue Shield Plans; and
- **Medically necessary** services, supplies, and procedures provided by **out-of-network providers** that have not contracted with us or any other Blue Cross and/or Blue Shield Plans

When you choose to receive **medically necessary** services, supplies, or care from a **provider** that does not contract with us, you will be responsible for any difference between our **allowable amount** and the amount charged by the **out-of-network provider**.

You will also be responsible for the charges incurred for services, supplies, and procedures limited or not covered under the **plan.**

Deductible(s)

Benefits under your **plan** will be available after you meet your **deductible(s)** as shown on your **SUMMARY OF BENEFITS**.

How individual deductibles work:

- **Benefits** will be available after your individual **deductible** amount, shown under your **SUMMARY OF BENEFITS,** have been met.

How family deductibles work:

- If a single-family member reaches the individual **deductible** shown under your **SUMMARY OF BENEFITS,** they will be eligible for **benefits** and do not have to wait for other family members to meet their **deductible**. This is known as an embedded family **deductible.**
- A family member may not apply more than the individual **deductible** amount toward the family **deductible** amount.
- Should two or more members of your family ever receive **covered services** due to injuries received in the same accident, only one program **deductible** will be applied against those **covered services**.

The **benefit period deductible** applies to all **covered services** except:

- **In-network provider** services that are subject to the office visit **copayment**
- Routine nursery care.
- Preventive care services received from an **in-network provider**. Preventive care services received from an **out-of-network provider** are subject to **deductible**, except for:
    - Annual mammography screening;
    - Covered childhood immunizations (for **members** under age 19-25);
    - Any other state or federally mandated benefits which stipulate a **deductible** may not be required.

Should the federal government adjust the **deductible** amount(s) applicable to this type of coverage, the **deductible** amount(s) will be adjusted accordingly.

The **deductible** and **out-of-pocket maximum** amounts under this **plan** follow applicable law. In case of a change in the law, the amounts will be adjusted accordingly.

Until the **benefit period deductible** is satisfied, **benefits** will be available only for those services or supplies for preventive services received from an **in-network provider** subject to a **copayment**, such as **physician** office visits, and emergency room facility charges, and **covered drugs** under **pharmacy benefits** unless otherwise listed as an exception above.

The following may be an exception to the **deductible(s)**:

If “three-month deductible carryover applies.” This means that any expenses incurred during the last three months of a **benefit period** can be applied towards the **benefit period deductible** for that **benefit period** and may be applied toward satisfaction of that **deductible** for the following **benefit period**.

Copayments (Copays)

Some of the care and treatment you receive under the **plan** will require that a **copayment** be paid at the time you receive the services. Refer to your **SUMMARY OF BENEFITS** for your **copayments.**

Copayments do not apply to services received from **out-of-network providers**.

The following **covered services** are not subject to an office visit **copayment**. **Benefits** will be provided at the payment levels shown in your **SUMMARY OF BENEFITS.** Services may be subject to **deductible** and/or **coinsurance** (if applicable):

- Any services provided during the office visit or at the time of consultation (i.e. lab and x-ray services)
- Surgery performed in the **physician's** office.
- Surgery performed in the urgent care center.
- Physical therapy billed separately from an office visit.
- Physical therapy billed separately from an urgent care visit.
- Occupational modalities in conjunction with physical therapy
- Allergy injections billed separately from an office visit.
- Therapeutic injections
- Any services requiring **prior authorization.**
- Certain diagnostic procedures
- Diagnostic imaging service such as:
    - magnetic resonance imaging (MRI)
    - computed tomography (CT)
    - positron emission tomography (PET)
    - myocardial perfusion studies (MPS)
    - other similar imaging tests
- Services provided by an independent laboratory, imaging center, radiologist, pathologist, and anesthesiologist.
- Outpatient treatment therapies or services such as radiation therapy, chemotherapy, and renal dialysis

Out-of-Pocket Maximum

The **out-of-pocket limit** is the total amount of **deductibles**, **copayments** and/or **coinsurance** which must be satisfied during your **benefit period** for all **covered services** received from **in-network providers** before we (your **plan**) will begin to cover all charges at 100% for the remainder of the **benefit period**.

The **out-of-pocket limit** will not include:

- Any penalty incurred due to your failure to follow the **plan's** requirements for **prior authorization.**
- Services, supplies, or charges limited or excluded by the **plan.**
- Expenses not covered because a benefit maximum has been reached.
- Any expense paid by the primary **plan** when BCBSOK is the secondary **plan** for purposes of coordination of **benefits.**
- **Copayments**
- **Copayments** paid for **out-of-network benefits.**
- Any **deductibles**
- Any **deductible** amount paid for **out-of-network benefits.**
- Any **copayments** paid under **pharmacy benefits.**

- Any pricing differences between the cost of **brand name drugs** and their generic equivalents that you pay under **pharmacy benefits.**
- Any additional charge for **non-participating pharmacy**
- Any **coinsurance** amounts paid for **out-of-network pharmacy benefits.**

The following are exceptions to the **out-of-pocket limit** described above:

- There are separate out-of-pocket limits for in-network benefits and out-of-network benefits.
- There are combined out-of-pocket limits for in-network benefits and out-of-network benefits.

Federal Balance Billing and Other Protections

This section is based upon the No Surprises Act, a federal law enacted in 2020 and effective for **plan years** beginning on or after January 1, 2022. Unless otherwise required by federal or Oklahoma law, if there is a conflict between the terms of this Federal Balance Billing and Other Protections section and the terms in the rest of this certificate, the terms of this section will apply.

Protections from Unexpected Costs for Medical Services from Non-Participating Providers

Your certificate contains provisions related to protection from surprise balance billing under applicable law. The federal laws provide additional financial protections for you when you receive some types of care from **providers** who do not participate in your **network**. If you receive the types of care listed below, your **in-network** cost-sharing levels will apply to any **network deductible** and **out-of-pocket maximums**. Additionally, your cost share amount may be calculated on an amount that generally represents the median payment rate that BCBSOK has negotiated with **participating providers** for similar services in the area. **Emergency care** from facilities or **providers** who do not participate in your **network:**

- Emergency care from an **out-of-network** providers or facilities.
- Care furnished by **out-of-network providers** during your visit to an **in-network** facility.
- Air ambulance services from **out-of-network providers** if the services would be covered by an **in-network providers.**

Out-of-network or non-**participating providers** may not bill you for more than your **deductible**, **coinsurance amount** or **copayments** for the service types referenced above. There are limited instances when an **out-of-network** or **non-participating provider** may send you a bill (for the care services referenced above) for up to the amount of that **provider**'s **billed charges**.

The requirements of federal law that impact your costs for care from non-**participating provider**s may not apply in all cases. Sometimes, Oklahoma law provisions relating to balance billing prohibitions may apply. You may contact us at the number on the back of your **identification card** with questions about claims or bills you have received from **providers**.

To the extent state and federal regulations are adopted or additional guidance is issued by federal regulatory agencies that alter the terms of this section, the regulations and any additional guidance will control over conflicting language in this section.

Continuity of Care

In the event you are under the care of an **in-network provider** and the **provider** stops participating in the **network** (for reasons other than failure to meet applicable quality standards, including medical

incompetence or professional behavior, or for fraud), we will continue providing coverage for you at the **in-network benefit** level if you have one of the following special circumstances:

- You are undergoing a course of treatment for a serious and complex condition.
- You are undergoing institutional or inpatient care.
- You are scheduled to undergo non-elective surgery from the **provider** (including receipt of post-operative care from such **provider** with respect to such surgery)
- You are pregnant or undergoing a course of treatment for the pregnancy.
- You are terminally ill

The continuity of coverage under this subsection shall continue until the treatment is complete but shall not extend for more than ninety (90) days, or more than nine (9) months if you have been diagnosed with a terminal illness, beyond the date the **provider's** termination from the **network** takes effect. If you are pregnant and you are in your second or third trimester of pregnancy at the time the **provider's** termination takes effect, continuity of coverage may be extended through delivery of the **child**, immediate postpartum care, and the follow-up check-up within the first six (6) weeks of delivery.

Coverage Determinations

Please note that we must determine services are **medically necessar**y in order to be covered under this **plan**.

Coverage of items and services provided to you is subject to our policies and guidelines, including, but not limited to:

- Medical
- Medical management
- Utilization or clinical review
- Utilization management
- Clinical payment and coding

These policies and guidelines may be updated throughout the plan year.

These policies are resources we use when making coverage determinations and lay out the procedure and/or criteria to determine if the following is **medically necessary**, eligible as a **covered service**, or is **experimental/investigational**, cosmetic, or a convenience item:

- Procedure
- Treatment
- Facility
- Equipment
- Drug
- Device

The clinical payment and coding policies are intended to ensure accurate documentation for services performed and require all **providers** to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act (HIPAA) approved code sets. Under the clinical

payment and coding policies, claims are required to be coded correctly according to industry standard coding guidelines including, but not limited to:

- Uniform Billing (UB) Editor
- American Medical Association (AMA)
- Current Procedural Terminology (CPT®)
- CPT® Assistant
- Healthcare Common Procedure Coding System (HCPCS)
- ICD-10 CM and PCS
- National Drug Codes (NDC)
- Diagnosis Related Group (DRG) guidelines
- Centers for Medicare and Medicaid Services (CMS)
- National Correct Coding Initiative (NCCI) Policy Manual
- CCI table edits
- Other CMS guidelines

Coverage for **covered services** is subject to the code edit protocols for services/procedures billed and claim submissions are subject to applicable claim review which may include, but is not limited to review of any terms of:

- Benefit coverage
- **Provider** contract language
- Medical and medical management policies
- Utilization or clinical review
- Utilization management policies
- Clinical payment and coding policies
- Coding software logic, including but not limited to lab management or other coding logic or edits

Any line of the claim that is not correctly coded and is not supported with accurate documentation (where applicable) may not be included in the covered charge and will not be eligible for payment by the plan. The clinical payment and coding policies apply for purposes of coverage regardless of whether the **provider** that rendered the item or service or submitted the claim is an **in-network** or **out-of-network provider**. The most up-to-date medical policies and clinical procedure and coding policies are available at www.bcbsok.com or by contacting Customer Service.

In addition to the **GLOSSARY** section of this benefit booklet, the following definitions apply to this section:

Serious and complex condition means:

- Acute illness - condition serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm (for example, if you are currently receiving chemotherapy, radiation therapy, or post-operative visits for a serious acute disease or condition)
- Chronic illness or condition - condition is:
    - life-threatening, degenerative, disabling or potentially disabling, or congenital, and
    - requires specialized medical care over a prolonged period of time.

COVERED SERVICES

This section describes **covered services** for which your **plan** pays **benefits** for you and your covered **dependents. Covered services** must also meet the criteria for **medically necessary**. Some services may require **prior authorization.** It is your responsibility to ensure that **prior authorization** is obtained or those services may carry a cost share penalty or a denial of payment. Refer to the **UTILIZATION MANAGEMENT** section or contact Customer Service by calling the number on the back of your **identification card** or visiting the Blue Access for Members℠ (BAM) website for additional information including which services may require **prior authorization**.

Some services may be **covered services** but are not listed in your booklet. For assistance determining if a service will be covered you may call the number on the back of your insurance **identification card**.

Covered services appear alphabetically.

Ambulances Services

Covered services include:

- **Medically necessary ambulance services.**

Ambulance services means transportation by means of a specifically designed and medically-equipped vehicle used for transporting the sick and injured, operated by an entity that is licensed and authorized as required by applicable law, to the closest facility appropriately equipped and staffed for treatment of your condition. The services may be on an emergency or non-emergency basis via ground or air (fixed wing or rotary) vehicles, depending on **medical necessity**.

Non-emergency transportation may require prior authorization to establish **medical necessity** prior to transport. Non-emergency ambulance transportation services provided primarily for the convenience of the p**articipant**, the p**articipant**'s family/caregivers or **physician**, or the transferring facility are considered not **medically necessary.**

Autism Spectrum Disorder

Covered services include:

- Psychiatric care, including diagnostic services.
- Psychological assessments and treatments
- Habilitative or rehabilitative treatments.
- Therapeutic care, including behavioral speech, occupational and physical therapies that provide treatment in the following areas:
    - Self-care and feeding.
    - Pragmatic, receptive, and expressive language.
    - Cognitive functioning.
    - **Applied behavior analysis** (ABA) intervention and modification.
    - Motor planning.
    - Sensory processing.

The following are **not covered services**:

- Magnetoencephalography.
- Elimination diets.
- Music, vision, art, animal, touch or massage therapies.

Autism spectrum disorder means a **neurobiological disorder** that includes autism, Asperger's syndrome, or pervasive developmental disorder--not otherwise specified.

A **neurobiological disorder** means an illness of the nervous system caused by genetic, metabolic, or other biological factors.

Behavioral Health
Mental Health and Substance Use Disorder Treatment

Covered services include:

- The treatment of mental health conditions provided by:
    - A **hospital**
    - Psychiatric **hospital**
    - **Residential treatment center**
    - **Other** plan-**approved** provider
- Outpatient visits with a physician, behavioral health provider
- Partial hospitalization treatment
- Intensive outpatient program
- Electro-convulsive therapy (ECT)
- Transcranial magnetic stimulation (TMS)

NOTE: **Covered services** for mental health and substance use disorder treatment include those delivered through **behavioral health** integration and the psychiatric collaborative care model.

NOTE: You or your **provider** may contact Customer Service at the number on the back of your **identification card** or visit our website at www.bcbsok.com for assistance with obtaining **covered services** for mental health and substance use disorders treatment from an **out-of-network provider** at the **in-network benefit** level, if such care is not available from an **in-network provider** within:

- 24 hours for emergency, urgent, or crisis care,
- 7 days for residential or hospitalization care, or
- 30 days for all other care.

The following are **not covered services**:

- **Behavioral health** services provided at behavioral modification facilities, boot camps, emotional group academies, military schools, therapeutic boarding schools, wilderness programs, halfway houses or group homes.

Biomarker Testing

Covered services includes **biomarker testing** for the purpose of any of the following:

- Diagnosis.
- Treatment.
- Appropriate management.
- Ongoing monitoring of your disease or condition to guide treatment when the test is supported by medical and scientific evidence.

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

Breast Cancer Screenings and Treatment

Benefits will be provided for **medically necessary** and clinically appropriate diagnostic examinations to evaluate abnormalities in the breast that are:

- Seen or suspected from a screening examination for breast cancer.
- Detected by another means of examination; or
- Suspected based on the medical history or family history of the individual.

Benefits will be provided for **medically necessary** and clinically appropriate supplemental examinations of the breast that are:

- Used to screen for breast cancer when there is no abnormality seen or suspected; and
- Based on personal or family medical history or additional factors that increase the individual's risk of breast cancer, including heterogeneously or extremely dense breasts.

These examinations may include, but are not limited to:

- Contrast-enhanced mammogram
- **Diagnostic Mammogram**
- **Breast Magnetic Resonance Imaging**
- **Breast Ultrasound**
- Molecular breast imaging

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

Breast Magnetic Resonance Imaging means a diagnostic tool used to produce detailed pictures of the structure of the breast.

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

The following are **not covered services**:

- Surgery performed for removal of breast implants that were implanted solely for cosmetic reasons are not covered.

Clinical Trials

Covered services include:

- Routine patient costs and related services you have from a provider in connection with participation in an approved clinical trial.

Related services are:

- Services in preparation for the non-covered service.
- Services in connection with providing the non-covered service.
- Hospitalization required to perform the non-covered service.
- Services that are usually provided following the non-covered service, such as follow up care or therapy after surgery.

The following are **not covered services**:

- The investigational item, device, or service itself
- Items or services that are provided solely for data collection or analysis.
- A service that is inconsistent with established standards of care for a give diagnosis
- Approved clinical trial means a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition.

Approved clinical trial means a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is one of the following:

- Any of the following federally funded or approved trials:
    - The Centers for Disease Control and Prevention of the United States Department of Health and Human Services;
    - The National Institutes of Health (NIH);
    - The Centers for Medicare and Medicaid Services;
    - The Agency for Healthcare Research and Quality;
    - A cooperative group or center of any of the previous entities;
    - The United States Food and Drug Administration;
    - The United States Department of Defense (DOD);
    - The United States Department of Veterans Affairs (VA);

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

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

Routine patient costs mean the cost for all covered items and services provided in this benefit booklet that are normally covered for you if you are not enrolled in a clinical trial.

Contraceptive/Birth Control Services

Covered services include contraceptive services when prescribed by a licensed provider such as:

- Contraceptive counseling.
- Examinations, procedures and medical services related to contraceptives.
- FDA approved **prescription drugs** and devices.

Covered services may also include female sterilization procedures for women (including, but not limited to tubal ligation, and not including hysterectomy) with reproductive capacity and contraceptive service **benefits**.

Covered services includes contraceptives in the following categories:

- Progestin-only contraceptives.
- Combination contraceptives.
- Emergency contraceptives.
- Extended-cycle/continuous oral contraceptives.
- Cervical caps.
- Diaphragms.
- Implantable contraceptives.
- Intra-uterine devices.
- Injectables.
- Transdermal contraceptives.
- Condoms.
- Vaginal contraceptive devices.

Cosmetic, Reconstructive, or Plastic Surgery

Covered services may include only those that are **medically necessary** for any of the following circumstances:

- Correction of defects caused by an **accidental injury.**
- Reconstructive surgery following cancer surgery or a mastectomy.

- Correction of a congenital defect, development deformity, functional impairment or craniofacial disfigurement and abnormalities.
- Breast implant removal resulting from sickness or injury.

The following are **not covered services**:

- Any services, surgery, procedures or supplies solely for cosmetic enhancement reasons.
- Breast implant solely for cosmetic reasons, breast implant removal of breast implants that were solely for cosmetic reasons.

Accidental injury means accidental bodily injury resulting, directly and independently of all other causes, in initial necessary care provided by a **physician** or **other professional provider.**

Dental Services for Accidental Injury

Covered services include:

- Oral surgery caused by accidental injury.
- The correction of damage caused by accidental injury.

For **medically necessary** dental services to be covered in a **hospita**l or surgery center your **provider** must certify that the dental care you receive could not be performed in the dentist's office due to a physical, mental, or medical condition.

The following are **not covered services**:

- Routine dental care.
- Standard dental treatments.
- Dental appliances.

Diabetic Equipment, Supplies and Self-Management

Covered services include any of the following for the treatment of type I, type II or gestational diabetes (prescribed by a **physician** or **other professional provider**):

- Diabetes self-management training in an inpatient or outpatient setting which enables you to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalizations and complications.
- Visits for re-education and refresher training.
- Medical nutrition therapy relating to diet, caloric intake and diabetes management.
- Equipment:
    - Blood glucose monitors.
    - Insulin pumps.
    - Lancet devices.
    - Supplies:
    - Test strips for glucose monitors.
    - Insulin syringes.
    - Lancets.

- Visual reading strips and urine test strips.
- Tablets which test for glucose, ketones and protein.
- Biohazard disposable containers.
- Glucagon emergency kit.

Diagnostic Services

Covered services include:

- Tests, scans, and procedures specifically designed to detect and monitor a condition or disease.

The following are covered diagnostic and diagnostic imaging service examples:

- Radiology and x-ray.
- Ultrasounds.
- Nuclear medicine.
- Laboratory and pathology.
- ECG, EEG, PET, CT, MRI and other electronic medical procedures.
- Bone Scan.
- Cardiac Stress Test.
- Myelogram.
- Sleep Studies.

Durable Medical Equipment

Covered services include:

- The rental and/or purchase of durable medical equipment with a written prescription for your therapeutic use. Rental equipment is not to exceed the total cost of the equipment. If you purchase your durable medical equipment the equipment will only be covered if you need it for long-term use.

The following are covered equipment examples:

- Wheelchair, cane, crutches, walker, ventilator, oxygen tank.
- Internal cardiac valves, internal pacemakers.
- External heart monitors (cardiac event detection monitoring device).

The following are examples of non-covered equipment:

- Modifications to home or vehicle such as: vehicle lifts or star lifts.
- Biofeedback equipment.
- Computer assisted communication devices.
- Replacement of lost or stolen durable medical equipment.
- Personal comfort, hygiene or convenience items such as support garments and air purifiers.
- Physical fitness equipment.

NOTE: For **durable medical equipment** and supplies obtained from an **out-of-network provider**, either because your **provider** deemed it necessary that you receive it within twenty-four (24) hours, or because there was not a **network provider** within fifteen (15) miles of your home address, the cost-sharing requirements will be the same as if they were obtained **in-network**.

Durable medical equipment also known as (DME) means equipment or supplies ordered by a health care provider that is:

- Appropriate for your use in your home, place of residence, or dwelling;
- Provides you therapeutic **benefits** or enables you to perform certain tasks that you would not be able to perform otherwise due to certain medical conditions and/or illnesses;
- Primarily serves a medical purpose and is generally not useful to you in the absence of an illness or injury; and
- The equipment can withstand repeated daily or extended use.

Emergency Services

Covered services include:

- **Emergency care** when you receive **covered services** that meet the definition of **emergency care** (see **GLOSSARY**) and services are received from an **in-network provider** or an **out-of-network provider** in a **hospital** emergency department.

Services provided in an emergency room that are not **emergency care** may be excluded from emergency coverage, although these services may be covered elsewhere in this Certificate if applicable. Non-emergency services provided in an emergency room for treatment of mental health and substance use disorder will be paid the same as **emergency care** services.

If you disagree with the plan's determination in processing your **benefits** as non-emergency care instead of emergency care, you may call Customer Service at the toll-free number on the back of your identification care. Please review the **CLAIM FILING AND APPEALS PROCEDURES** section of this Certificate for specific information on your right to seek and obtain a full and fair review of your claim.

Hearing Aids and Audiological Services

Covered services include:

- Prescribed electronic hearing aids installed in accordance with a prescription written during a covered hearing exam by a licensed audiologist or **other provider** acting within the scope of their license.
- Audiological services and hearing aids, limited to:
    - One hearing aid per ear every 48 months; and
    - Up to four additional ear molds per **benefit period** of **medically necessary.**

The following are **not covered services**:

- Replacement of a hearing aid that is lost, stolen or broken
- Replacement parts or repairs for a hearing aid
- Batteries or cords

Hearing aid means any wearable, non-disposable instrument or device designed to make up for impaired hearing including the parts, attachments or accessories.

Hearing Exams

Covered services include:

- A hearing exam for the evaluation of hearing impairment, hard of hearing or hearing loss.

Hearing exam must be performed by a hearing specialist such as an audiologist.

Home Health Care

Covered services include:

- **Home health care** visits with a **hospital** program for home health care or an independent licensed home health care agency.

Visits may include:

- Professional services of an RN, LPN or LVN.
- Medical social service consultations.
- Health aide services while you are receiving covered nursing or therapy services.
- Services of a licensed registered dietitian or licensed certified nutritionist, when authorized by your supervising **physician** and when **medically necessary** as part of diabetes self-management training.
- Medical and surgical supplies.
- Prescribed drugs.
- Oxygen and its administration.

The following are not **covered services:**

- Dietitian services, except as specified for diabetes self-management training.
- Homemaker services.
- Maintenance therapy.
- Speech Therapy.
- Durable Medical Equipment.
- Food or home-delivered meals.
- Infusion Therapy, except when you have received **prior authorization** from the us for these services.

Hospice Care

Covered services include:

- Inpatient, outpatient or hospice facility agency services.
- In-home services which are part of a plan of care.

Hospice care may be covered when:

- You have a terminal illness with a life expectancy of one year or less, as certified by your attending **physician.**
- You no longer benefit from standard medical care or have chosen to receive **hospice care** rather than other standard care.

The following are **not covered services**:

- Home delivered meals.
- Homemaker services.
- Transportation services.
- **Custodial care.**

Hospice Care means an integrated set of services designed to provide palliative and supportive care for terminally ill patients.

Infertility Treatment

Covered services include:
Diagnosis of infertility and treatment of the underlying cause. Infertility Treatment services are limited to the amount specified in the **SUMMARY OF BENEFITS**.

Infusion Therapy

Covered services include:

- Infusion and injectable therapy.

Infusion therapy means the administration of medication through a needle or catheter. It is prescribed when a patient's condition is so severe that it cannot be treated effectively by oral medications. Typically, "**infusion therapy**" means that a drug is administered intravenously, but the term also may refer to situations where drugs are provided through other non-oral routes, such as intramuscular injections and epidural routes (into the membranes surrounding the spinal cord). **Infusion therapy** in most cases requires health care professional services for the safe and effective administration of the medication.

Inherited Gene Mutation Testing

Benefits will be provided for **medically necessary** clinical genetic testing for an inherited gene mutation for individuals with a personal or family history of cancer and for evidence-based cancer imaging for individuals with an increased risk of cancer, when recommended by your **provider**.

Inpatient Hospital Admission

Covered services include:

- Inpatient care received in a **hospital** setting, this includes:
    - Bed, board and general nursing care when you are in a semi-private room, an intensive care unit or a private room.
- Ancillary services such as:
    - Anesthesia supplies and services rendered by an **employee** of the **hospital** or **other professional provider.**
    - Diagnostic services.
    - Lab work.
    - Medical and surgical dressings, supplies, casts and splints.
    - Operating, delivery and treatment rooms.
    - Oxygen.

*If you are in a private room, **benefits** will be limited by the **hospital's** rate for its most common type of room with two or more beds, unless you are required under the infection control policy of the **hospital** to be in isolation to prevent contagion.

Inpatient services are subject to the prior authorization requirements of this Certificate. If you fail to comply with these requirements, benefits for covered services rendered during your inpatient confinement will be reduced by $0-1,000, provided the plan determines that benefits are available upon receipt of a claim.

Maternity Care

Covered services include:

- Prenatal and postnatal care at a **physician's** office.
- **Physician** services for delivery.
- Inpatient care at a **hospital** or birthing center licensed as a **hospital** following delivery for the birthing parent and newborn **child** covered under the **plan** for a minimum of:
    - 48 hours following an uncomplicated vaginal delivery
    - 96 hours following an uncomplicated delivery by caesarean section
- If a vaginal delivery occurs at home or in a birthing center that is not licensed as a **hospital** but that is accredited as a freestanding birth center by the Commission for the Accreditation of Birth Centers, your **plan** provides coverage for one home visit within 48 hours of childbirth by a licensed health care **provider** whose scope of practice includes providing postpartum care. Postdelivery care may be provided at the birthing parent's home, a health care **provider's** office or a health care facility. Postdelivery care visits shall include, at a minimum:
- Physical assessment of the birthing parent and newborn infant;
- Parent education regarding childhood immunizations;
- Training or assistance with breast or bottle feeding; and
- Performance of any medically necessary and appropriate clinical tests

Charges for **well-baby nursery care**, including the initial examination and administration of a newborn screening test during the birthing parent's **hospital admission** for the delivery will be considered inpatient **hospital** services and will be subject to the benefit provisions and benefit maximums.

Well-baby nursery care does not include treatment or evaluation for medical or surgical reasons during or after the birthing parent's maternity inpatient hospital stay. In the event the newborn requires such treatment or evaluation while covered under this Certificate:

- The infant will be considered as a **member** in its own right and will be entitled to the same **benefits** as any other **member** under this Certificate
- A separate **deductible** will apply to the newborn's inpatient hospital stay

The following are **not covered services**:

- For or related to the planned delivery of a newborn **child** at home, or in any setting other than a **hospital**, accredited freestanding birthing center, or other facility licensed to provide such services
- Ductal lavage of the mammary ducts
- Testing of cervicovaginal fluid for amniotic fluid protein during pregnancy, which might be ordered in people suspected to have fluid leaking from around the baby (premature ruptured membranes).

Maternity care means care and services provided for treatment of the condition of pregnancy, other than complications of pregnancy.

Well-baby nursery care means routine nursery care visits to examine a newborn **member**, limited to the first 48 hours following a vaginal delivery or 96 hours following delivery by cesarean section. No additional inpatient hospital visits are covered for newborn **well-baby nursery care**.

Complications of pregnancy means conditions, requiring **hospital** confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as:

- Acute nephritis
- Nephrosis
- Cardiac decompensation
- Missed miscarriage
- Miscarriage
- Similar medical and surgical conditions of comparable severity

The following are **not covered services**:

- For or related to the planned delivery of a newborn child at home, or in any setting other than a hospital, accredited freestanding birthing center, or other facility licensed to provide such services
- Ductal lavage of the mammary ducts
- Testing of cervicovaginal fluid for amniotic fluid protein during pregnancy, which might be ordered in people suspected to have fluid leaking from around the baby (premature ruptured membranes).

Organ and Tissue Transplant

Covered services include:

- Transplant surgery, services and treatment related to organ or tissue transplant provided by a **physician** and/or **hospital** for the **participant** and the donor.

The following criteria apply:

- **Prior authorization** for the transplant procedure has been obtained as required under your **plan**
- You meet the criteria established by us in pertinent written medical policies
- You meet the protocols established by the **hospital** in which the transplant is performed.
- Transplants must be performed in or by a provider that meets the criteria established by the **plan** for assessing and selecting providers for transplants

The following are **not covered services**:

- Living and/or travel expenses of the recipient or a live donor
- Purchase of the organ or tissue; or organs or tissue (xenograft) obtained from another species.

Orthotic and Prosthetic

Covered services include:

- Leg, arm, back, neck, or other body braces.
- A prosthetic device that your **provider** orders and fits (including external breast prostheses after mastectomy).
- Adjustments, repair and subsequent replacements due to wear or change in your physical condition.

The following are **not covered services**:

- Test sockets for prosthetic.
- Waterproof/water resistant prosthetics.
- Carbon fiber running foot/blade.

Outpatient Services

Covered services include:

- Services performed at a medical facility without an overnight stay and are not referenced elsewhere in the **COVERED SERVICES** section of this benefit booklet. Examples of outpatient services:
- Biomarker testing
- Chemotherapy
- Inherited gene mutation testing
- Radiation therapy treatments
- Renal dialysis treatment
- Respiratory therapy
- Surgery
- Urgent Care

Prostate Cancer Detection Tests

Covered services include:

An annual medically recognized diagnostic, physical examination for the detection of prostate cancer.

A prostate-specific antigen test used for the detection of prostate cancer .

Services Delivered Via Telemedicine

Covered services include:

- The diagnosis and treatment of certain non-emergency medical and **behavioral health** conditions or illnesses when a telemedicine **provider** determines that your diagnosis and treatment can be done without an in-person office visit for:
    - Primary care.
    - Convenient care.
    - Emergency room care.
    - Behavioral health care.
    - Urgent care.

Not all medical or **behavioral health** conditions can be treated by telemedicine visit. Your telemedicine **provider** will identify any condition for which treatment should be performed by an in-person **provider**. **Benefits** may be limited consistent with the coding and clinical standards recognized by the American Medical Association or the Centers for Medicare and Medicaid Services, or as otherwise allowed by applicable law.

Telemedicine visits mean the diagnosis, consultation or treatment provided by a licensed **provider** through one or more technology-enabled **health and care management** and delivery systems that extend capacity and access to care.

Skilled Nursing Facility Services

Covered services include skilled nursing facility services.

Skilled nursing facility care includes:

- Bed, board and general nursing care.
- Ancillary services (such as drugs and surgical dressings or supplies).
- Physical, occupational, speech, and respiratory therapy services by licensed therapists.

The following are **not covered services**:

- Continued skilled nursing visits if you no longer improve from treatment.
- Care in the home is not available or the home is unsuitable for such care.
- For **custodial care**, or care for someone's convenience.

Speech-Language

Covered services include:

Those of a **physician** or licensed speech therapist to diagnose, treat, prevent or restore speech, language, voice and swallowing disorders from birth through old age.

Urgent Care

Covered services include:

Services and supplies to treat an urgent condition at an urgent care center.

PREVENTIVE CARE

Preventive **covered services** are intended to help keep you healthy, supporting you in achieving your best health through early detection. A preventive **covered service** will be considered **medically necessary covered services** and will not be subject to any **deductible**, **coinsurance**, **copayment** and/or **benefit** maximum when such services are received from an **in-network provider** or **participating pharmacy.** Preventive care services from **out-of-network providers** may be subject to **deductible**, **copayment** and/or **coinsurance**, except for certain state or federally mandated **benefits** (example: childhood immunizations). Preventive **covered services** are intended to help keep you healthy, supporting you in achieving your best health through early detection.

The following agencies set the preventive care guidelines:

- United States Preventive Services Task Force ("USPSTF") for recommendations of evidence-based items or services that have in effect a rating of "A" or "B".
- Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") for recommended immunizations.
- Health Resources and Services Administration ("HRSA") for evidence-informed preventive care and screenings with respect to women.
- American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.

The above agencies' recommendations and guidelines may be updated periodically. When updated, they will apply to your **plan.**

Preventive drugs (including both prescription and over-the-counter products) that meet the preventive recommendations described above, and that are listed on the No-Cost Preventive **Drug List**, will be covered. Coverage will be implemented in the quantities and within the time period allow under applicable law. These drugs will not be subject to any **copayment** amount, **coinsurance** amount, **deductible**, or dollar maximum when obtained from a **participating pharmacy**. Drugs on the No-Cost Preventive **Drug List** obtained from a non-participating pharmacy may be subject to **copayment** amount, **coinsurance** amount, **deductibles**, or dollar maximums, if applicable.

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

Breastfeeding Support and Services
Covered services include:

- During pregnancy or after delivery when you get them from a certified **provider**:
  - Breastfeeding support services.
  - Breastfeeding counseling.

Breast Pump, Accessories and Supplies

Covered services include, with a **prescription order,** either:

- Rental of **hospital** grade breast pumps (not to exceed the total cost)
- Purchase of manual or electric breast pumps

Benefits for electric breast pumps are limited to one per **benefit period**.

Preventive Cancer Screening Tests

Covered services include, but are not limited to**:**

- A diagnostic, medically recognized screening exam for the detection of colorectal cancer for **participants** who are at normal risk for developing colon cancer, and a follow-up colonoscopy if the findings are abnormal

To see a listing of the preventive health services available to you at no cost through an **in-network provider** visit www.healthcare.gov/coverage/preventive-care-benefits/ or call the number on the back of your insurance **identification card.**

For frequencies and any limits that may apply, contact your **physician** or visit https://www.bcbsok.com/provider/clinical/clinical-resources/preventive-care.

Benefits for High Deductible Health Plan – Health Savings Account (HDHP-HSA) Preventive Drug Program

In addition to the preventive care services, your **benefits** include coverage for certain outpatient **prescription drugs**, that are covered under the HDHP-HSA Preventive Drug Program, when prescribed by a qualified **provider**.

Benefits for outpatient **prescription drugs** and medicines covered under the HDHP-HSA Preventive Drug Program provided by a **preferred participating pharmacy** or **participating pharmacy** will not be subject to **coinsurance**, **deductible**, and/or **copayment** when prescribed for preventive purposes. **Benefits** for outpatient **prescription drugs** and medicines covered under this program will not be subject to any **deductible**, **coinsurance**, and/or **copayment** when obtained from a **preferred participating pharmacy** or **participating pharmacy** when prescribed for preventive purposes.

Benefits for outpatient **prescription drugs** and medicines covered under this program will be subject to **non-participating pharmacy** cost sharing when provided by a **non-participating pharmacy**. You will not be subject to any **deductible**. **Benefits** for outpatient **prescription drugs** and medicines covered under this program will not be subject to any **deductible**, **coinsurance**, and/or **copayment** when obtained from a **non-participating pharmacy**.

This program includes outpatient **prescription drugs** in the following drug categories (This list of drug categories is not all inclusive and may be subject to change. Please confirm with your **plan** the categories that apply):

- Antianginal (Anti-Angina)
- Anti-Coagulants/Anti-Platelets

- Anti-Coagulants Preferred Brand
- Anti-Platelets Preferred Brand
- Bowel Prep Medications
- Breast Cancer Primary Prevention
- Contraceptives
- Depression – Selective Serotonin Reuptake Inhibitors (SSRIs)
- Diabetes Medications – GLP1 Orals & Other Injectables
- Diabetes Medications – GLP1 Orals and Other Injectables Preferred Brand
- Diabetes Medications – Hypoglycemic Agents
- Diabetes Medications – Insulin Only
- Diabetes Medications – Oral Only
- Diabetes Medications – Oral Only Preferred Brands (SGLT2, DPP4, DPP4+SGLT2)
- Diabetic Supplies
- Diabetic Supplies – Continuous Glucose Monitors & Associated Supplies
- Diabetic Supplies – Insulin Pumps and Associated Supplies
- Fluoride Supplements (Fluoride)
- High Blood Pressure (Antihypertensives)
- High Cholesterol Injectable PCSK-9s (Lipid Lowering – Injectable)
- High cholesterol Orals (Lipid Lowering)
- Osteoporosis
- Prenatal Vitamins
- Respiratory (Asthma/COPD)
- Respiratory – Respiratory Devices and Supplies (Spacers)
- Smoking cessation (Tobacco Cessation)
- Transplant (Anti-Rejection) and
- Vaccines.

These drugs could also at times be prescribed for treatment purposes. If your **provider** has prescribed a listed drug for treatment purposes (and not preventive purposes) then it will be subject to any applicable **deductible**, **coinsurance**, **copayment** and /or benefit maximum.

NOTE: For more information on drugs covered under your **plan** refer to the **PHARMACY BENEFITS** portion of this benefit booklet.

For additional information about specific drugs included in this program, contact Customer Service at the number on the back of your insurance **identification card**.

MEDICAL LIMITATIONS AND EXCLUSIONS

The following are not **covered services** under your **plan**. Refer to the **COVERED SERVICES** section of your benefit booklet for exclusions associated with specific services or supplies.

What is Not Covered

- Any services or supplies that are not **medically necessary.**
- Any services not prescribed by or performed by or upon the direction of a **physician** or **other provider.**
- Any services or supplies determined to be **experimental/investigational** or unproven.
- Clinical technology, services, procedures, and service paradigms designated by a temporary (CPT Category III) code are not covered, except for certain services otherwise specified by state or federal law, or federal coverage or billing guidelines.
- Any services or supplies provided by a member of your immediate family.
- Any services received before the **covered person's effective date.**
- Any services received after the **covered person's** coverage stops.
- Any services or supplies provided in connection with an occupational sickness or an injury sustained in the scope of and in the course of any employment whether or not benefits are, or could upon proper claim be, provided under the Workers' Compensation law.
- You agree to:
    - Pursue your rights under the workers' compensation laws;
    - Take no action prejudicing the rights and interests of the plan; and
    - Cooperate and furnish information and assistance the plan requires to help enforce its rights.
- If you receive any money in settlement for your employer's liability, regardless of whether the settlement includes a provision for payment of your medical bills, you agree to:
    - Hold the money in trust for the benefit of the plan to the extent that the plan has paid any **benefits** or would be obligated to pay any **benefits**; and
    - Repay the plan any money recovered from your employer or insurance carrier
- Any illness or injury suffered after the participant's effective date as a result of war or any act of war, declared or undeclared, when serving in the military or any auxiliary unit thereto.
- Any services or charges for which you have no legal obligation to pay in the absence of this or like coverage.
- Any services received from a dental or medical department maintained by or on behalf of an **employer**, mutual benefit association, labor union, trust, or similar person or group.
- Any services, supplies or drugs provided to a **covered person** outside the United States, except for **Emergency Care**.
- Any care and services, including rehabilitation care and services, unless documentation can be provided that, due to the nature of the services rendered or your condition, you cannot receive safe or adequate care as an outpatient.
- Any charges:
    - Resulting from the failure to keep a scheduled visit with a **physician** or **other provider**
    - For completion of any insurance forms.

- For acquisition of medical records.
- Resulting from failure to pay your cost share(s).
- Incurred while not covered under this **plan.**

- Services for foot care only to improve comfort or appearance such as:
  - Care for flat feet
  - Subluxation
  - Corns
  - Bunions (except capsular and bone surgery)
  - Calluses
  - Toenails
- Routine services, screening or periodic physical examinations which are not specified in the **PREVENTIVE CARE** section of this benefit booklet.
- Reverse sterilization.
- Female contraceptive devices when not prescribed by a licensed **provider**, including over-the-counter contraceptive products. Contraceptive medications or devices for male use are excluded.
- Orthognathic Surgery, osteotomy or any other form of oral surgery, dentistry or dental processes to the teeth and surrounding tissue (including complications resulting therefrom) except as listed in the **COVERED SERVICES** section of this benefit book.
- Inpatient treatment of any non-covered dental procedure, except:
  - **Ambulatory surgical facility** services, and anesthesia services associated with any **medically necessary** dental procedure when provided to a **covered person** who is severely disabled;
  - or who has a medical or emotional condition which requires hospitalization or general anesthesia for dental care;
  - or who, in the judgment of the treating **practitioner**, is not of sufficient emotional development to undergo a **medically necessary** dental procedure without the use of anesthesia.
- Orthoptic training, eyeglasses, contact lenses or examinations for prescribing or fitting them, except for:
  - Aphakic patients (including lenses required after cataract surgery) and soft lenses or sclera shells to treat disease or injury.
  - Vision examinations performed in connection with the diagnosis or treatment of disease or injury.
  - Services specified under THE **PREVENTIVE CARE** section of the benefit booklet.
- Eye surgery such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).
- Refractions, including:
  - Lens prescriptions.
  - Corrective eyeglasses and frames.

- Contact lenses (including the fitting of the lenses).
- Toric or accommodating intraocular lens implants except as may be specifically provided for in the **SUMMARY OF BENEFITS**. Refractive surgery is excluded.

- Gender reassignment surgery or any treatment leading to or in connection with gender reassignment surgery.
- Any services or supplies provided for, in preparation for, or in conjunction with any of the following, except **standard fertility preservation services** to treat **iatrogenic infertility**:
  - Sterilization reversal
  - Treatment of sexual dysfunctions not caused by organic disease
  - Artificial insemination
  - Ovulation induction procedures
  - In vitro fertilization
  - Embryo transfer
  - Any other procedures, supplies or medications which in any way are intended to augment or enhance your reproductive ability.
- Treatment of sexual dysfunction not caused by organic disease.
- Treatment, services or supplies of obesity, including, but not limited to:
  - Weight reduction or dietary control programs.
  - Prescription or nonprescription drugs or medications (whether to be taken orally or by injection), appetite suppressants, or nutritional supplements.
- Services or supplies for smoking cessation programs and the treatment of nicotine addiction. With the exception of prescription and over-the-counter drugs for tobacco cessation, which may be covered under the **PREVENTIVE CARE** section of this benefit booklet.
- Services related to conditions such as hyperkinetic syndromes, learning disabilities, behavioral problems, mental retardation or for inpatient confinement for environmental change. This exclusion ***shall not*** apply to the following **medically necessary** services:
  - Services of a **physician** or **other provider** (except for neuropsychological testing) related to the diagnosis and treatment of attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD); or
  - **Prescription drug** therapy (provided the **plan** includes **benefits** for outpatient **prescription drugs**) for treatment of ADD/ADHD.
- For unspecified developmental disorders, except as specified in the **COVERED SERVICE** section under **Autism Spectrum Disorder**.
- Family or marital counseling.
- Hippotherapy, equine assisted learning or other therapeutic riding programs.
- Treatment of temporomandibular joint dysfunction (TMJ).
- Continuous Passive Motion (CPM) devices used in treatment of the shoulder or other joints, except for up to 21 days postoperatively for certain knee procedures determined to be **medically necessary** per our medical policy.
- 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.

- Thermal capsulorrhaphy as a treatment of joint instability, including, but not limited to, instability of shoulders, knees and elbows.
- Elective abortion, unless the life of the birthing parent is endangered.
- Transcutaneous electrical nerve stimulator (TENS).
- Inpatient drug and alcohol treatment that is not rendered in a **hospital**, psychiatric **hospital**, **residential treatment center** or other **plan**-approved **provider.**
- Massage therapy, including, but not limited to:
    - Effleurage
    - Petrissage
    - Tapotement
- Transportation services, except as described under **Ambulance Services** in the **COVERED SERVICES** section of this benefit booklet.
- Services which are not specifically named as **covered services** subject to any other specific exclusions and limitations in this benefit booklet.
- Any illness or injury suffered after the participant's effective date as a result of war or any act of war, declared or undeclared, when serving in the military or any auxiliary unit thereto.
- Cannabis, meaning all parts of the plant genus Cannabis containing delta-9-tetrahydrocannabinol (THC) as an active ingredient, whether growing or not, the seeds of the plant, the resin extracted from any part of the plant, and every cannabis-derived compound, manufacture, salt, derivative, mixture or preparation of the plant, its seeds, or its resin. Cannabis with THC as an active ingredient may be called marijuana.
- Select medications may be excluded from the medical benefit when a self-administered formulation of the product is available.
- Viscosupplementation (intra-articular hyaluronic acid injection), except for individuals currently receiving maintenance therapy.

The **plan** may, without waiving these **MEDICAL LIMITATIONS AND EXCLUSIONS**, elect to provide **benefits** for care and services while awaiting the decision of whether or not the care and services fall within the **Exclusions** listed above. If it is later determined that the care and services are excluded from your coverage, we will be entitled to recover the amount we have allowed for **benefits** under the **plan.** See the **GENERAL PROVISIONS** section for more information.

PHARMACY BENEFITS

Your **plan** may not cover all **prescription drugs** and some coverage may be limited. This does not mean you cannot get **prescription drugs** that are not covered; you can, but you may have to pay for them yourself. For more information about prescription drug **benefits** see your prescription **SUMMARY OF BENEFITS**. You may also contact customer service by calling the number on the back of your **identification card** or access Blue Access for Members℠ (BAM) for any questions regarding your **prescription drug benefits**.

We share the cost with you for **medically necessary covered prescription drugs** if the prescription drug:

- Is on the **drug list.**
- Has been approved by the United States Food and Drug Administration (FDA) for at least one indication.
- Is recognized by the following for treatment of the indication for which the drug is prescribed:
- A **prescription drug** reference compendium approved by the Department of Insurance
- Substantially accepted peer-reviewed medical literature.

You are responsible for any **deductibles**, **copayment** and/or **coinsurance** amounts, and pricing differences shown on your **SUMMARY OF BENEFITS** that may apply to any **covered prescription drug** dispensed**.**

Your Cost

Benefits are provided for **prescription drugs** dispensed for your use when recommended by and while under the care of a **physician** or **other provider**, provided such care and treatment is **medically necessary**.

Benefits for **prescription drugs** are available to you only:

- In accordance with a **prescription drug order**; and
- After you have met the **deductible**, if applicable; and
- After you have incurred charges equal to the **copayment** and/or **coinsurance** applicable to each **prescription drug order. If the charge for your prescription is less than your copayment and/or coinsurance, you will pay the lesser amount.**

When **prescription drugs** and related services are dispensed by a **participating pharmacy** and after the **deductible** has been satisfied, the **plan** will pay directly to the **pharmacy** the **allowable charge** for the drugs, less the applicable **deductible**, **copayment** and/or **coinsurance** specified in the **SUMMARY OF BENEFITS for PHARMACY BENEFITS**.

If your **prescription drug order** is filled by an **out-of-network pharmacy**, you will need to:

- Pay the full cost of the drugs directly to the **pharmacy.**
- Then submit a claim to us in order to receive any **benefits** under this program.

In addition to any **deductible**, and **copayment** and/or **coinsurance** amounts applicable to your coverage, you will be responsible for the cost difference, if any, between the **pharmacy**'s **billed charges** and the **allowable charge** determined by the **plan**. **NOTE:** Vaccinations administered by a **pharmacy** that is not a **participating retail pharmacy vaccination network provider** are not covered under this **PHARMACY BENEFITS** section**.**

You may not be required to pay the difference in cost between the **allowable charge** of the **brand name drug** and the **allowable charge** of the **generic drug** if there is a medical reason (e.g., adverse event) you need to

take the **brand name drug** and certain criteria are met. Your **provider** can submit a request to waive the difference in cost between the **allowable charge** of the **brand name drug** and **allowable charge** of the **generic drug**. In order for this request to be reviewed, your **provider** must:

- Send in a MedWatch form to the Food and Drug Administration (FDA) to let them know the issues you experienced with the generic equivalent.
- Provide a copy of this form when requesting the waiver.

The FDA MedWatch form is used to document adverse events, therapeutic inequivalence/failure, product quality problems, and product use/medication error. This form is available on the FDA website.

If the waiver is granted, applicable **copayment** and/or **coinsurance** amounts will still apply. For additional information, contact the customer service number on the back of your **identification card** or visit www.bcbsok.com.

- Any **copayment** and **coinsurance** amounts for **prescription drug orders** filled at a **participating pharmacy** or **specialty network pharmacy** will accumulate toward satisfaction of your **deductible** and **out-of-pocket limit** for "**Network Provider** Services."
- Any **copayment** and **coinsurance** amounts for **prescription drug orders** filled at an **out-of-network pharmacy** or any **pharmacy** other than a **specialty network pharmacy** will accumulate toward satisfaction of your **out-of-network deductible** and **out-of-pocket limit.**
- **Out-of-Network**, non-specialty claims will be stopped at the point of sale. The **member** pays for the drug upfront and is required to submit a paper claim for reimbursement.
- If a **covered prescription drug** was paid for using a manufacturer's coupon or **copayment** card, the coupon or **copayment** card amount will apply to your **plan deductible** or **out-of-pocket limit**.

Covered Services

Benefits are provided for **outpatient prescription drugs** and related services, limited to the following:

- **Prescription drugs** means that are required by federal and state law to be dispensed only by prescription.
- **Prescription drugs** dispensed for a **covered person's outpatient** use, when recommended by and while under the care of a **physician or other provider**.
- Injectable insulin and insulin products, but only when dispensed according to a written **prescription order by** a licensed **physician** or other **provider** even though a **prescription drug order** may not be required by law.
- Oral contraceptives, when prescribed by a licensed **physician** or other **provider**.
- **Prescription drugs** prescribed for treatment of attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD).
- Orally administered anticancer drugs that are used to kill or slow the growth of cancerous cells when prescribed by a licensed **physician**.
    - Our **deductible**, **copayment** and/or **coinsurance** amount will not apply to orally administered anticancer medications when received from a **participating pharmacy**.
    - Coverage of prescribed orally administered anticancer medications when received from a non-preferred specialty pharmacy **provider** or non-participating **pharmacy provider** will be subject to applicable **deductible**, **copayment** and/or **coinsurance**; however, **benefits** will be provided on a basis no less favorable than intravenously administered or injected cancer medications.
- Self-injectable and other self-administered **prescription drugs** (including Chemotherapy), when

dispensed by a **pharmacy**.

- Self-injectable and other self-administered drugs purchased, dispensed or administered from a **physician** and administered in their office are not covered.
- Many self-injectable/self-administered drugs are classified as "specialty pharmacy drugs" and should be purchased from a participating **specialty** pharmacy in order to receive the highest level of **benefits**.

- **Specialty pharmacy drugs**, **limited to a 30-day supply per Prescription Order**, are limited to a 30-day supply. However, some have FDA approved dosing regimens exceeding the 30-day supply limits and may be allowed greater than a 30-day supply. **Benefits** will be subject to the **deductible**, **copayment** and/or **coinsurance** provisions.
- Select vaccinations (when administered by **participating pharmacies** in the **pharmacy vaccination network**).
  - For a current listing of vaccines available through this coverage, calls Customer Service at the number listed on your **identification card** or visit our website at www.bcbsok.com.
  - NOTE: Select vaccinations administered through **participating pharmacies** in the **pharmacy vaccination network** are not subject to the **deductible**, **copayment** and/or **coinsurance** provisions of this **plan**.
- Drugs prescribed by a **physician** or other **provider** as part of **Preventive Care Services** as defined in this benefit booklet (including both prescription and over-the-counter drugs) which have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF") or as required by state law. Drugs classified for **preventive care** will be provided in the quantities and within the time periods allowed under applicable law. Such drugs are not subject to the **copayment**, **coinsurance** and/or **deductible** provisions of this **plan** when obtained from a **participating pharmacy**.

  NOTE: Prescription drugs that are approved by the FDA through the accelerated approval program may be considered **experimental/investigational** and may not be covered.

In order to be a **covered drug** under this **PHARMACY BENEFITS** section, the **prescription drugs** must be shown on the **drug list**. The drugs on the **drug list** have been selected to provide coverage for a broad range of diseases. Each drug appearing on the list shows to which tiered category it belongs. For example, most **generic drugs** are categorized as Tier 1 or Tier 2 drugs, while specialty drugs may be classified as Tier 5 or Tier 6 drugs (depending upon the **benefit plan** in which you are enrolled). You may refer to the **SUMMARY OF BENEFITS for PHARMACY BENEFITS** to determine the level of coverage available for each drug tier/category.

- Tier 1 – includes mostly **preferred generic drugs** and may contain some **brand name drugs.**
- Tier 2 – includes mostly **non-preferred generic drugs** and may contain some **brand name drugs**.
- Tier 3 – includes mostly **preferred brand name** drugs and may contain some **generic drugs**.
- Tier 4 – includes mostly **non-preferred brand name drugs** and may contain some **generic drugs**.
- Tier 5 – includes mostly **preferred specialty drugs** and may contain some **generic drugs**.
- Tier 6 – includes mostly **non-preferred specialty drugs** and may contain some **generic drugs**.

The **drug list** is subject to periodic review and change by the **plan**. A current list is available on our website at www.bcbsok.com. You may also contact a Customer Service Representative at the number shown on your **identification card** for more information.

As new drugs are approved by the Food and Drug Administration (FDA), such drugs, unless the intended use is specifically excluded under this benefit booklet, will be reviewed by the **plan** and may be added to the applicable **drug list** and be eligible for **benefits** as outlined in the **SUMMARY OF BENEFITS for Outpatient Prescription Drugs and Related Services**.

Drug List Exception Requests

You or your **provider** can ask for a **drug list** exception if your drug is not on the **drug list**. To request this exception, you or your **provider** can call the number on the back of your **identification card** to ask for a review.

If you have a health condition that may jeopardize your life, health or keep you from regaining function, or your current drug therapy uses a non-**covered prescription drug**, you or your **provider** may be able to ask for an expedited review process. Otherwise:

- We will let you and your **provider** know the coverage decision within 72 hours after we receive your request for an expedited review.
- If the coverage request is denied, we will let you and your **provider** know why it was denied and may offer you a covered alternative drug (if applicable).

If your review is expedited, BCBSOK will usually let you or your provider know of the coverage decisions within 24 hours of receiving your request. Call the number on the back of your **identification card** if you have any questions.

Selecting a Pharmacy

Participating Pharmacy

When you go to a **participating pharmacy**:

- Present your **identification card** to the pharmacist along with your **prescription order**
- Provide the pharmacist with the birth date and relationship of the patient
- Sign the insurance claim log
- Pay the appropriate **copay** for each **prescription order** filled or refilled and the pricing difference when it applies to the **covered drug** you receive

Participating pharmacies have agreed to accept as payment in full the least of:

- The billed charges
- The **allowable amount** as determined by the **claim administrator**
- Other contractually determined payment amounts

You may be required to pay for limited or non-covered services. No claim forms are required.

You can go to the **pharmacy** of your choice. However, we may cover more of the cost of your prescription drugs when you receive them from a **preferred participating pharmacy**. **Preferred participating pharmacies** may charge less than **participating pharmacies**. Refer to your **SUMMARY OF BENEFITS** for information on what you pay for prescription drugs.

If you are unsure whether a **pharmacy** is a **preferred participating pharmacy** or a **participating pharmacy**, you may access our website at www.bcbsok.com or contact the customer service helpline telephone number shown in this benefit booklet or on your **identification card**.

Non-Participating Pharmacy

If you have a **prescription order** filled or obtain a covered vaccination at a non-participating **pharmacy**, you will pay the **pharmacy** the total cost. You may submit a claim form to us with itemized receipts verifying that the **prescription order** was filled or a covered vaccination was provided. We will reimburse you for **covered drugs** and covered vaccinations less:

- The appropriate **copay** and/or **coinsurance** and **deductible**, if any
- Any pricing differences that may apply to the **covered drug** or covered vaccination you receive.

You will not be reimbursed for any charges over our **allowable amount** for the **covered drugs**. Any dollar amount you pay for prescription drugs dispensed from a **non-participating pharmacy** will not go towards your **out-of-pocket maximum**.

However, you may submit the documentation with a claim form to us, and allowable credit will, as applicable, be applied towards your **in-network deductible** and **out-of-pocket maximum** if:

- You directly pay a non-**participating pharmacy** a rate less than the average discounted rate which would be paid by us to a **participating pharmacy** for a covered and **medically necessary** service or supply; and
- The non-**participating pharmacy** does not submit a claim to us for that service or supply

Then you may submit the documentation with a claim form to us, and allowable credit will, as applicable, be applied towards your **in-network deductible** and **out-of-pocket maximum**.

Specialty Pharmacy Drug Program

The **specialty pharmacy drug program** provides delivery of medications directly to your health care **provider** for administration or to the home of the patient that is undergoing treatment for a complex medical condition. To receive the highest level of **benefits**, **specialty drugs** should be obtained through an **in-network specialty pharmacy**.

Coverage for **specialty drugs** is limited to a 30-day supply. However, some **specialty drugs** have FDA approved dosing regimens exceeding the 30-day supply limits and may be allowed greater than a 30-day supply. Cost share will be based on day supply (1-30-day supply, 31-60-day supply, 61-90-day supply) dispensed.

To determine which drugs are specialty drugs, you should refer to the plan's website at https://www.bcbsok.com/ok/documents/rx-drugs/specialty-drug-list-ok.pdf or by contacting Customer Service at the toll-free number on your **identification card**. Your cost will be the appropriate **deductible**, and **copayment** and/or **coinsurance** amount indicated in the **SUMMARY OF BENEFITS for PHARMACY BENEFITS.**

Extended Prescription Drug Supply Program

Your coverage includes **benefits** for up to a 90-day supply of **maintenance prescription drugs** purchased from a **participating pharmacy** which may only include **preferred participating** retail or **participating mail order** pharmacies.

- Benefit amounts are listed in the **SUMMARY OF BENEFITS for PHARMACY BENEFITS**.
- Your cost will be the appropriate **copayment**, **coinsurance**, and/or **deductible** indicated in the **SUMMARY OF BENEFITS for PHARMACY BENEFITS**.

Benefits will not be provided for more than a 30-day supply of drugs obtained from a **prescription drug provider** *not* participating in the **extended prescription drug supply program**.

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

Mail-Order Pharmacy Program

The **plan** has selected a **mail-order pharmacy program** to fill and deliver maintenance (long-term) medications. This program provides delivery of **maintenance prescription drugs** directly to your home. All items that are covered under the **mail-order pharmacy program** are subject to the same limitations and exclusions as the **retail pharmacy program**. **Note:** Items covered through a specialty pharmacy are not covered through the mail-order pharmacy program.

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

Your cost will be the appropriate **deductible**, and **copayment** and/or **coinsurance** amount indicated in the **SUMMARY OF BENEFITS for PHARMACY BENEFITS.**

If you send an incorrect payment amount for the **prescription drug order** dispensed, you will either:

- Receive a credit if the payment is too much
- Be billed for the appropriate amount if it is not enough

Retail Pharmacy Program

Benefits you receive and the amount you pay will vary depending upon the type of drugs**,** or supplies obtained and whether they are obtained from a **preferred participating pharmacy**, **participating pharmacy** or **out-of-network pharmacy**. Your cost will be the appropriate **deductible**, and **copayment** and/or **coinsurance** amount indicated in the **SUMMARY OF BENEFITS for PHARMACY BENEFITS.**

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

Member Pay the Difference

If you receive a **brand name drug** when a **generic drug** equivalent is available, you will be responsible for the difference between the **allowable charge** for the **brand name drug** and the **allowable charge** for the **generic drug** equivalent. This amount is in addition to any **copayment** and/or **coinsurance** amount provided in the **SUMMARY OF BENEFITS for PHARMACY BENEFITS** and does apply to the **deductible** or **out-of-pocket limit**.

Prescription Drug Prior Authorization and Step Therapy Process

We have designated certain drugs which require **prior authorization** in order for **benefits** to be available under the **plan**.

You can obtain a listing of the drugs which require **prior authorization** or **step therapy** by visiting our website at www.bcbsok.com or contacting a Customer Service Representative at the number shown on your **identification card**. Also, you may request a listing by writing to the **Prescription Drug Benefits** address located in the **CUSTOMER SERVICE** section of this Certificate.

NOTE: the listing of drugs requiring **prior authorization** or **step therapy** will change periodically as new drugs are developed or as required to assure **medical necessity**.

If your **physician** or other **provider** prescribes a drug which requires prior approval, you, the **physician** or other **provider** may request a **prior authorization** review or a **step therapy** exception by calling Customer Service at the number listed on your **identification card** or visiting our website at www.bcbsok.com. Your request will be reviewed within the required time frames. If you have a health condition that may jeopardize your life, health or keep you from regaining function, you or your **provide**r may be able to ask for an expedited review process.

When you present your **prescription order** to a **participating pharmacy**, along with your **identification card**, the pharmacist will submit an electronic claim to us to determine the appropriate **benefits**.

- If the **prior authorization** or **step therapy** exception request is approved, your pharmacist will dispense the **prescription drug** as prescribed and collect any applicable **deductible**, and **copayment** and/or **coinsurance** amount.
- If the **prior authorization** or **step therapy** exception request is denied, you will be responsible for the full cost of your prescription.
- If you purchase your prescriptions from an **out-of-network** (**non-participating**) **pharmacy**, or if you do not have your **identification card** with you when you purchase your prescriptions, it will be your responsibility to pay the full cost of the **prescription drugs** and to submit a claim form (with your itemized receipt) to receive any **benefits** available under your **prescription drug** program. Send the completed claim form to the **Prescription Drug Claims** address located in the **CUSTOMER SERVICE** section of this Certificate.
    - If the drug you received is one which requires prior approval, we will review the claim to determine if **prior authorization** approval would have been given.
    - If so, **benefits** will be processed in accordance with your **prescription drug** coverage.
    - If the **prior authorization** approval is denied, no **benefits** will be available under this Certificate for the **prescription drug order**.

To view a listing of the drugs which are included in the prior authorization[/step therapy] program, please visit our website at www.bcbsok.com/prescription-drugs/managing-prescriptions/drug-lists. If you have questions about step therapy, or prior authorization, please call a Customer Service Representative at the number shown on your identification card for assistance.

You or your **provider** can ask for a step therapy exception. To request this exception, you or your **provider** can call the number on the back of your **identification card** or visit our website at www.bcbsok.com to ask for a review.

- We will respond to you and your provider within 72 hours after we receive your request.
    - If the timeframe for a response ends on a weekend or a legal holiday, the timeframe for the response shall run until the close of the next full business day.

- If the prescribing provider indicates that you have a health condition that may jeopardize your life, health or keep you from regaining function, we will respond to such request within 24 hours after we receive your request.
    - If the timeframe for a response ends on a weekend or a legal holiday, the timeframe for the response shall run until the close of the next full business day.
- If we fail to respond within the required time, the step therapy exception request shall be deemed granted.
- If the request is denied, we will let you and your provider know why it was denied.

If your exception is denied, you may appeal the decision according to the appeals process you will receive with the denial determination. Call the number on the back of your identification card if you have any questions.

Step therapy programs do not apply to prescription drug treatment for the treatment of **advanced, metastatic cancer** or **associated conditions.**

Coverage for prescription drug treatment for **advanced, metastatic cancer** or **associated conditions** do not require you to fail to successfully respond to a different drug or provide a history of failure of a different drug, before providing coverage of a prescription drug. This applies only to a prescription drug treatment that is consistent with best practices for the treatment of **advanced, metastatic cancer** or an **associated condition**; supported by peer-reviewed, evidence-based literature; and approved by the FDA.

Prescription Drug Supply/Dispensing Limits

The **plan** has the right to determine the day supply or unit dosage limits as its sole discretion. **Benefits** may be denied if drugs are dispensed or delivered in a manner intended to change or having the effect of changing or circumventing the stated maximum supply limitations. Some drugs covered under your plan may be subject to certain supply/fill limitations pursuant to diagnoses or new-to-therapy requirements, plan design, and/or state or federal regulations. For specific drug supply/fill information, please call the customer service toll-free number located on your identification card.

Benefit Supply Limits per Prescription Order

For each **copayment** and/or **coinsurance** amount specified for your **prescription drug** program, you can obtain the following supply of a single **prescription drug** or other item covered under this program (unless otherwise specified).

Benefits will be provided for **prescription drugs** dispensed in the following quantities:

- **Retail Pharmacy and Specialty Pharmacy Network Providers** – During each one-month period, up to a 30-day supply, for **prescription drugs** and **specialty pharmacy drugs.** However, some specialty drugs have FDA approved dosing regimens exceeding the 30-day supply limits and may be allowed greater than a 30-day supply, if allowed by your Plan Benefits. Cost share will be based on day supply (1-30-day supply, 31-60-day supply, 61-90- day supply) dispensed.
- **Extended Prescription Drug Supply Program and Mail-Order Pharmacy Program** – During each three-month period, up to a 90-day supply, for drugs designated by the **plan** as **maintenance prescription drugs**.

Benefits are not provided under this **plan** for charges for **prescription drugs** dispensed in excess of the above stated amounts.

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

Prescription contraceptive drugs are available for up to a six-month supply.

Clinical Dispensing Limits Applicable to Certain Drugs

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

Oncology Split Fill Program

If this is your first time using select medications (e.g. cancer medications) or medications that has not been filled within 120 day, you may only be able to receive a partial fill (14-15 day supply) of the medication for up to the first 3 months of therapy. This is to help see how the medication is working for you. If you receive partial fill, your **copayment** and/or **coinsurance** after your **deductible** will be adjusted to align with the quantity of medication dispensed. If the medication is working for you and your **physician** or other **provider** wants you to continue on this medication, you may be eligible to receive up to a 30-day supply after completing up to 3 months of the partial supply. For a list of drugs that are included in this program, please visit the https://www.bcbsok.com/rx-drugs/pharmacy/pharmacy-programs website.

Controlled Substances Limitation

If the **plan** determines that a **covered person** may be receiving quantities of controlled substance medications not supported by FDA approved dosages or recognized safety or treatment guidelines, any coverage for such medications may be subject to a review to determine **medical necessity**, appropriateness and other coverage restrictions which may include but not limited to limiting coverage to services provided by a certain **provider** and/or **pharmacy** for the prescribing and dispensing of the controlled substance medication and/or limiting coverage to certain quantities. Additional **copayment** and/or **coinsurance** may apply. For the purposes of this provision, controlled substance medications are medications are drugs and other substances included under the Controlled Substances Act (CSA). Substances are placed in their respective schedules based on whether they have a currently accepted medical use in the treatment in the United States, their relative abuse potential, and likelihood of causing dependence when abused.

Therapeutic Equivalent Restrictions

Some drugs have therapeutic equivalents/therapeutic alternatives under multiple names. In some cases, **benefits** may be limited to only certain therapeutic equivalents/therapeutic alternatives. If you do not choose the therapeutic equivalents/therapeutic alternatives that are covered under this **benefit** section, the drug purchased will not be covered under any **benefit** level.

In addition to the **GLOSSARY** section of this benefit booklet, the following definitions apply to this section:

Prior authorization means that in order to determine that a drug is safe, effective, and part of a specific treatment plan, certain medications may require **prior authorization** and the evaluation of additional clinical information and criteria before the drug is covered under your **prescription drug** program.

Step therapy program means a "step" approach to providing **benefits** for certain medications your **physician** or other **provider** prescribes for you. This means that you may first need to try one or more "prerequisite" clinically acceptable alternative medications before certain medications identified on the **step therapy drug list** are approved for coverage under your **prescription drug** program.

- Although you may currently be on therapy, your claim may need to be reviewed to see if the criteria for coverage of further treatment has been met.
- A documented treatment with a prerequisite medication or other exception may be required for continued coverage of the drug identified on the **step therapy drug list**.
- Please refer to the *"Step Therapy Exception Requests"* in this **PHARMACY BENEFITS** for information regarding exception requests.

The following definitions are applicable to this step therapy benefit:

- Advanced, metastatic cancer means a cancer that has spread from the primary or original site of the cancer to nearby tissues, lymph nodes, or other areas or parts of the body.
- Associated conditions mean the symptoms or side effects associated with advanced, metastatic cancer or its treatment and which, in the judgment of the provider, further jeopardize the health of a patient if left untreated.

PHARMACY LIMITATIONS AND EXCLUSIONS

In addition to the exclusions and limitations specified in the **MEDICAL LIMITATIONS AND EXCLUSIONS** section of the **benefit booklet**, no **benefits** will be provided under this **PHARMACY BENEFFITS** section for:

- Drugs/products which are not included on the **drug list**, unless specifically covered elsewhere in this benefit booklet and/or such coverage is required in accordance with applicable law or regulatory guidance.
- Non-FDA approved drugs.
- Drugs that are not considered **medically necessary** or treatment recommendations that are not supported by evidence-based guidelines or clinical practice guidelines.
- Drugs which by law do not require a **prescription drug order** from an authorized **provider** (except insulin, insulin analogs, insulin pens and prescriptive and nonprescriptive oral agents for controlling blood sugar level); and drugs, insulin or covered devices for which no valid **prescription drug order** is obtained.
- Over-the-counter drugs and medications, except those prescribed by a **physician** or **other provider** as part of the **PREVENTIVE CARE** as defined in this benefit booklet.
- Devices or, technologies, and/or **durable medical equipment** of any type (even though such devices may require a **prescription order**), such as, but not limited to, contraceptive devices, therapeutic devices, artificial appliances, digital health technologies and/or applications, or similar devices (**except** lancets, test strips, and disposable hypodermic needles and syringes for self-administered injections). However, coverage for prescription contraceptive devices is provided under the **COVERED SERVICES** section of this benefit booklet.
- Pharmaceutical aids such as excipients found in the USP-NF (United States Pharmacopeia-National Formulary) including but not limited to, preservatives, solvents, ointment bases, and flavoring, coloring, diluting, emulsifying and suspending agents.
- Administration or injection of any drugs (except for select vaccines administered by a **participating pharmacy**).
- Vitamins (**except** those vitamins which by law require a **prescription drug order** and for which there is **no** non-prescription alternative).
- Drugs dispensed in a **physician**'s office or during confinement while a patient in a **hospital**, or other acute care institution or facility, including take-home drugs; and drugs dispensed by a nursing home or custodial or chronic care institution or facility.
- **Covered prescription drugs**, devices, or other **pharmacy** services or supplies for which **benefits** are, or could upon proper claim be, provided under any present or future laws enacted by the Legislature of any state, or by the Congress of the United States, including but not limited to:
    - Any services or supplies for which **benefits** are payable under Part A and Part B of Title XVIII of the Social Security Act (Medicare),
    - The laws, regulations or established procedures of any county or municipality, except any program which is a state **plan** for medical assistance (Medicaid),
    - Any **prescription drug** which may be properly obtained without charge under local, state, or federal programs, unless such exclusion is expressly prohibited by law; provided, however, that this exclusion shall not be applicable to any coverage held by you for **prescription drug** expenses which is written as a part of or in conjunction with any automobile casualty insurance policy.

- **Covered prescription drugs** for which the **pharmacy**'s usual and customary charge to the general public is less than or equal to the **copayment** and/or **coinsurance** amount provided under this benefit booklet.
- **Infertility** and fertility medications.
- Prescription contraceptive devices or non-prescription contraceptive materials (**except** oral contraceptive medications which are **prescription drugs**). However, coverage for prescription contraceptive devices is provided under the **COVERED SERVICES** section of this benefit booklet.
- Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations except those prescribed by a **physician** or **other provider** as part of the **PREVENTIVE CARE** as defined in this benefit booklet.
- Drugs required by law to be labeled: "Caution — Limited by Federal Law to Investigational Use", or Experimental, Investigational and/or Unproven drugs, even though a claim is made for the drugs.
- **Covered prescription drugs** or devices dispensed in quantities in excess of the amounts stipulated in this **PHARMACY BENEFITS** section; or refills of any **prescription orders** in excess of the number of refills specified by the **physician** or **other provider** or by law; or any drugs or medicines dispensed more than one year following the **prescription drug order** date.
- Drugs which are not approved by the U.S. Food and Drug Administration (FDA) for a particular use or purpose or when used for a purpose other than the purpose for which the FDA approval is given, except as required by law or regulation. This exclusion is not applicable to the coverage of the off-label use of **prescription drugs** for the treatment of cancer or the study of oncology in accordance with Oklahoma law.
- Fluids, solutions, nutrients, medications (including all additives and chemotherapy) used or intended to be used by intravenous or gastrointestinal (enteral) infusion or by intravenous, intramuscular (in the muscle), intrathecal (in the spine), or intraarticular (in the joint) injection in the home setting, except as specifically provided in this Certificate. NOTE: This exception does not apply to dietary formula necessary for the treatment of phenylketonuria (PKU) or other heritable diseases.
- Drugs prescribed and dispensed for the treatment of obesity or for use in any program of weight reduction, weight loss or dietary control.
- Drugs for the use or intended use of which would be illegal, unethical, imprudent, abusive, not **medically necessary** or otherwise improper.
- Drugs obtained by unauthorized, fraudulent, abusive or improper use of the **identification card**.
- Drugs used or intended to be used in the treatment of a condition, sickness, disease, injury or bodily malfunction which is not covered under this Certificate, or for which **benefits** have been exhausted.
- Rogaine, Minoxidil or any other drugs, medications, solutions, devices or preparations used or intended for use in the treatment of hair loss, hair thinning or any related condition, whether to facilitate or promote hair growth, to replace lost hair, or otherwise.
- Any smoking cessation products, including those which require a **prescription drug order.**
- Cosmetic drugs used primarily to enhance appearance, including but not limited to, correction of skin wrinkles and skin aging.
- **Prescription drug orders** for which there is an over-the-counter product available with the same active ingredient(s), in the same strength, unless otherwise determined by the **plan.**
- Retin-A or pharmacologically similar topical drugs.
- Athletic performance enhancement drugs.

- Drugs to treat sexual dysfunction or erectile dysfunction, including but not limited to, sildenafil citrate (Viagra), phentolamine (Regitine), alprostadil (Prostin, Edex, Caverject), and apomorphine.
- Compounded medications. For purposes of this exclusion, "compounded medications" are customized medications made by mixing, assembling, packaging, or labeling drugs that are not commercially available in a specific dosage form, strength or formulation.
- Replacement of drugs or other items that have been lost, stolen, destroyed or misplaced.
- Shipping, handling or delivery charges.
- Non-sedating antihistamine drugs and combination medications containing a non-sedating antihistamine and decongestant.
- **Brand name** proton pump inhibitors.
- Repackagers, institutional packs, clinic packs, or other custom packaging.
- Drugs determined by us to have inferior efficacy or significant safety issues.
- Diagnostic agents, except diabetic testing supplies or test strips.
- Bulk powders.
- Any self-injectable and other self-administered drugs purchased from a **physician** and administered in their office.
- Any self-administered drugs dispensed by a **physician**.
- Cannabis, meaning all parts of the plant genus Cannabis containing delta-9-tetrahydrocannabinol (THC) as an active ingredient, whether growing or not, the seeds of the plant, the resin extracted from any part of the plant, and every cannabis-derived compound, manufacture, salt, derivative, mixture or preparation of the plant, its seeds, or its resin. Cannabis with THC as an active ingredient may be called marijuana.
- New-to-market FDA-approved drugs which are subject to review by Prime Therapeutics Pharmacy and Therapeutic (P&T) Committee prior to coverage of the drug.

UTLIZATION MANAGEMENT

Utilization Management

Utilization management may be called a medical necessity review, which is used for a procedure, service, inpatient admission, and/or length of stay and is based on our medical policy and nationally recognized criteria.

Medical Necessity reviews may occur:

- Prior to care.
- During care.
- After care has been completed.

Please refer to **medical necessity** or **medically necessary** in the **GLOSSARY** section of this **benefit booklet** for additional information regarding any limitations and/or special conditions pertaining to your **benefits**.

Prior Authorization

You need pre-approval from us for some **covered services**. Pre-approval is also called **prior authorization**. This ensures that certain **covered services** will not be denied based on **medical necessity** or **experimental/investigational**.

Prior authorization does not guarantee payment of **benefits**. For additional information and a current list of health care services that require **prior authorization**, please visit our website at https://www.bcbsok.com/provider/claims/claims-eligibility/utilization-management/pa-lists.

Prior Authorization Responsibility

In-Network Provider Prior Authorization

When required, your **in-network provider** is responsible for obtaining **prior authorization**. If your **in-network provider** does not obtain **prior authorization** and the services are denied as not **medically necessary**, the **in-network provider** will be held responsible.

Out-of-Network Prior Authorization

If an **out-of-network provider** recommends an admission or service that requires **prior authorization**, you are responsible for obtaining **prior authorization.** Call the number on the back of your **identification card.**

Note: **Providers** that **contract** with other Blue Cross and Blue Shield **plans** are not familiar with the **prior authorization** requirements of BCBSOK. Unless a **provider contracts** directly with BCBSOK as a participating **provider**, the **provider** is not responsible for being aware of this **plan's prior authorization** requirements, except as described in the section "The BlueCard® Program" in the **GENERAL PROVISIONS**.

If the service is determined to be **medically necessary**, **out-of-network benefits** will apply. However, if **prior authorization** is not obtained before services are received and determined to be not **medically necessary**, you may be responsible for the charges.

Response to Prior Authorization Requests

The **plan** will provide a written response to your prior authorization request within 7 days of obtaining all necessary information to make the decision. This period may be extended one time for up to 15 additional days, if we determine that additional time is necessary due to matters beyond our control.

If the **plan** determines that additional time is necessary, we will notify you in writing, prior to the expiration of the original 7-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 **plan** expects to make the determination.

If an extension of time is necessary due to our need for additional information, we will notify you of the specific information needed, and you will have 45 days from receipt of the notice to provide the additional information. We will provide a written response to your request for **prior authorization** within 15 days following receipt of the additional information.

The procedure for appealing an adverse Prior Authorization determination is set forth in the section entitled, **CLAIM FILING AND APPEALS PROCEDURE**.

Response to Prior Authorization Requests Involving Urgent Care

A **prior authorization** request involving urgent care is any request for medical care or treatment with respect to which the 7-day review period set forth above:

- This could seriously jeopardize your life or life or health or your ability to regain maximum function; or
- in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the **prior authorization** request.

The **plan** will respond to you within 72 hours of obtaining all necessary information to make the decision. If you fail to provide sufficient information, you will be notified of the missing information within 24 hours and will have no less than 48 hours to provide the information. A benefit determination will be made as soon as possible (taking into account medical exigencies) but no later than 72 hours after the initial request, or within 48 hours after the missing information is received (if the initial request is incomplete).

The **plan's** response to your **prior authorization** 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.

Length Of Stay/Service Review

Upon completion of the **prior authorization** process for inpatient services or the **prior authorization** requests involving emergency care review, the **plan** will send a letter to you, your physician, **behavioral health** practitioner and/or **hospital** or facility with a determination on the approved length of service or length of stay.

An extension of the length of stay/service will be based solely on whether continued inpatient care or other health care service is **medically necessary**. If the extension is determined not to be **medically necessary**, the coverage for the length of stay/service will not be extended, except as otherwise described in the **CLAIM FILING AND APPEALS PROCEDURE** section under this Certificate.

A length of stay/service review, also known as a concurrent **medical necessity** review, is when you, your **provider**, or other authorized representative may submit a request to the **plan** for continued services. If you, your **provider** or authorized representative requests to extend care beyond the approved time limit and it is a request involving urgent care or an ongoing course of treatment, the **plan** will make a determination within 72 hours of receipt of the request.

Recommended Clinical Review Option

A r**ecommended clinical review** is:

- An optional voluntary **medical necessity** review for a **covered service** that does not require a **prior authorization.**
- Occurs before, during or after services are completed.
- Limits situations where you must pay for a non-approved service.

To determine if a **recommended clinical review** is available for a specific service, please visit our website at www.bcbsok.com/find-care/utilization-management for the **recommended clinical review** list.

Contacting Medical and Behavioral Health

You may contact us for a **prior authorization** or **recommended clinical review** by calling the toll-free telephone number on the back of your **identification card** and following the prompts to the Medical or **Behavioral Health** Unit or via the member portal.

Post-Service Medical Necessity Review

A **post-service medical necessity review** is sometimes referred to as a retrospective review or post-service claims request and determines:

- Your eligibility.
- Availability of **benefits** at the time of service.
- **Medical necessity.**

Failure to Obtain Prior Authorization

If **prior authorization** is not obtained:

- You may be responsible for a penalty for certain **covered services**, if indicated on your **SUMMARY OF BENEFITS**.
- If we determine the treatment or service is not **medically necessary** or is experimental/investigational, **benefits** will be reduced or denied.
- We will review the **medical necessity** of your treatment or service prior to the final benefit determination.

CLAIM FILING AND APPLEALS PROCEDURES

Filing of Claims Required

When you receive care and **covered services** from an **in-network provider**, the **provider** will usually submit your claim directly to us, but it is your responsibility to make sure we receive your claim. There may be **providers**, **ambulatory surgical facilities**, and/or **hospitals** who do not have an agreement with BCBS.

When you receive care and **covered services** from an **out-of-network provider**, you may be required to file your own claim.

The instructions for filing your own claim are in the chart below.

Filing a Medical Claim	Requirement	Deadline
Notice of Claim	Once we receive your written notice, we will provide you or your employer with the claim forms for filing a proof of loss claim within 15 days. You may also obtain claim forms by contacting Customer Service at the number on the back of your identification card or visiting our website at www.bcbsok.com.	If the claim forms are not provided within 15 days, we will accept a written description that must detail the nature and extent of loss within 90 days of your loss.
Proof of Loss (Claim)	A completed claim form and any additional information required. File each **participant's** expenses separately. **Deductibles** and **benefits** are applied to each **participant** separately. Include itemized bills from the **provider**, labs, etc., on their letterhead showing the services given, dates of service, charges, and **participant's** name.	**Proof of loss** must be provided to us within 180 days after the end of the **benefit period** for which the claim is made. We won't void or reduce your claim if you can't send us notice and **proof of loss** within the required time if you show the claim was given as soon as reasonably possible.
Benefit Payment	Written proof must be provided for all **benefits**. If any portion of a claim is contested by us**,** the uncontested portion of the claim will be paid after the receipt of **proof of loss**.	**Benefits** will be paid within the time period required by law once the necessary proof to support the claim is received.

Our Receipt of Claims

A claim will be considered received by us for processing upon actual delivery to our administrative office in the proper manner and form and with the required information. If the claim is not complete, it may be denied, or we may contact either you or the **provider** for additional information.

For additional information and claim forms, please visit www.BCBSOK.com.

Filing a Prescription Drug Claim	Requirement	Deadline
Mail-Order Program	A completed mail service **prescription drug** claim form	Within 90 days. **Proof of loss** may not be given later than 1 year after the time proof is otherwise required, except if you are legally unable to notify us.
Prescription Drug Claims	A completed Prescription Reimbursement Claim Form Include itemized bills from the **pharmacy** showing the name, address, and telephone number of the **pharmacy**, **participants prescription drugs** received, including the name and quantity of the drug, prescription number and date of purchase	Within 90 days. **Proof of loss** may not be given later than 1 year after the time proof is otherwise required, except if you are legally unable to notify us.

Please mail completed claim forms to:

Medical Claims	**Prescription Drug Claims**
Blue Cross and Blue Shield of Oklahoma Claims Division PO Box 655924 Dallas, TX 75265-5924	Prime Therapeutics LLC PO Box 25136 Lehigh Valley, PA 18002-5136

Who Receives Payment

Benefit payments for **covered services** are made directly to contracting **providers** when they bill us. If you submit a timely claim for **covered services** from a non-contracting **provider**, we reserve the right to make **benefit** payments to you. If unpaid at your death, any **benefits** payable to you will be paid to your beneficiary or to your estate.

Except as provided in the **ASSIGNMENT AND PAYMENT OF BENEFITS** section**,** or as permitted by applicable law, rights and **benefits** under the **plan** are not assignable before or after services and supplies are provided.

Review of Claim Determinations

Claim Determinations

When we receive a properly filed claim, we have authority and discretion under the **plan** to interpret and determine **benefits** in accordance with the **plan's** provisions. You have the right to a review by us of any determination of a claim, a request for **prior authorization**, or any other determination made by us concerning your **benefits** under the **plan**.

Note: If we are going to discontinue coverage of **prescription drugs** or intravenous infusions that you are receiving, we will notify you at least 30 days before the date coverage will be discontinued.

Timing of Required Notices and Extensions

There are three types of claims as defined below:

- **Urgent care clinical claim** means any pre-service claim that requires **prior authorization**, as described in this **benefit booklet**, for medical care or treatment and your **physician** determines that a delay in getting medical care or treatment could put your life or health at risk; or a delay might put your ability to regain maximum function at risk. It could also be a situation in which you need care to avoid severe pain that cannot be adequately managed without the care or treatment.
- **Pre-service claim** means any non-urgent request for **benefits** that involves services you have not yet received and requires **prior authorization**.
- **Post-service claim** means notification in a form acceptable to us that a service has been rendered or furnished to you.
    - This notification must include full details of the service received, including:
        - Your name, age, and gender
        - Identification number
        - Name and address of the **provider**
        - An itemized statement of the service rendered or furnished
        - Date of service
        - Diagnosis
        - Claim charge
        - Any other information which we may request in connection with services rendered to you.

Type of Notice (Claim) or Extension	Time Period
Urgent Care Clinical Claim	
If your claim is incomplete, the **claims administrator** must notify you within:	24 hours

Type of Notice (Claim) or Extension	Time Period
If you are notified that your claim is incomplete, you must provide information to complete your claim to the us within:	48 hours after receiving notice
If we deny your initial claim, we must notify you of the denial:	
If the initial claim is complete (taking into consideration medical needs), within:	72 hours. If you are an inpatient at a healthcare facility when services are recommended, we will issue a determination within 24 hours after we receive the request.
If the initial claim is complete, as soon as possible (taking into account medical exigencies), no later than:	72 hours.
After receiving the completed claim (if the initial claim is incomplete), within:	48 hours.
Pre-Service Claims	
If your claim is filed improperly, we must notify you within:	5 days
If your claim is incomplete, we must notify you within:	15 days
If you are notified that your claim is incomplete, you must then provide completed claim information to us within:	45 days after receiving notice
If we deny your initial claim, we must notify you of the denial:	
If the initial claim is complete within:	15 days
After receiving the completed claim (if the initial claim is incomplete), within:	30 days
Post-Service Claims (Retrospective Review)	
If your claim is incomplete, you will be notified within:	30 days after claim is received
If you are notified that your claim is incomplete, you must then provide completed claim information to us within:	45 days after receiving notice
We must notify you of any adverse claim determination:	

Type of Notice (Claim) or Extension	Time Period
If the initial claim is complete within:	45 days for a paper claim and 30 days for an electronic claim
After receiving the completed claim (if the initial claim is incomplete), within:	45 days for a paper claim and 30 days for an electronic claim

We may extend the initial 30-day period one time for up to 15 days, only if we determine that an extension is necessary. We will notify you in writing, prior to the expiration of the initial 30−day period of the reasons why an extension of time is necessary and the date we expect to decide. If the initial 30-day period is extended because we require additional information from you or your **provider**, we will specifically describe the required information in the notice and you will be given at least 45 days from receipt of the notice within which to provide us with the requested information. The period for us deciding is paused from the date we send the notice of extension to you until the date you respond to the request for additional information or until the additional information was to be submitted, whichever date is earlier.

If a Claim Is Denied or Not Paid in Full

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

- Reasons for the determination.
- A reference to the **group health plan** provisions or the contractual, administrative, or protocol basis for the determination.
- A description of additional information necessary and an explanation of why it is necessary.
- Subject to privacy laws and other restrictions, if any:
    - Identification of the claim.
    - Date of service.
    - Health care **provider**.
    - Claim amount (if applicable).
    - Statement describing denial codes with their meanings and standards used.
    - Diagnosis/treatment codes with their meanings and the standards used (upon receipt).
- An explanation of our internal review/appeals and external review processes and the time limits applicable to such procedures (and how to initiate a review/appeal or external review).
- A statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on internal review/appeal.
- A statement in non-English language(s) that written notice of claim denials and certain other benefit information may be available (upon request) in such non-English language(s) (in certain situations).
- A statement in non-English language(s) that indicates how to access the language services provided by us (in certain situations).
- Copies of all documents, records, and other information relevant to the claim (provided free of charge on request).

- Either copies of any internal rule, guidelines protocol or similar criterion relied upon or a statement that such a rule, guidelines, protocol, or tother similar criterion was relied upon and a copy of such rule, guideline protocol or other criterion will be provided free of charge upon request.
- Urgent care clinical claims.:
    - Description of the expedited review procedure applicable.
    - Decision may be provided orally, so long as a written notice is given to the claimant within 3 days of verbal notification.
- Contact information for applicable office of health insurance consumer assistance or ombudsman (as appropriate).

Claim Appeal Procedures

Claim Appeal Procedures and Definitions.

Adverse Benefit Determination means our determination that the health care services you have received, or may receive are:

- **Experimental, investigational** and/or unproven.
- Not **medically necessary** or appropriate.

An adverse determination includes a denial, reduction, or termination of a benefit, a pre-service claim, urgent care clinical claim, and a benefit resulting from a utilization review, treatment previously approved being reduced or terminated, or not paying (in whole or in part) for a benefit or claim.

Expedited Clinical Appeal means an appeal of a clinically urgent nature related to a denial of health care services, including, but not limited to:

- Procedures or treatments ordered by a **provider.**
- **Emergency care.**
- Continued hospitalization.
- A step therapy exception request.
- If you were receiving **prescription drugs** or intravenous infusions and coverage was discontinued.

If your situation meets the definition of an expedited clinical appeal, you may be able to appeal our decision on an expedited basis.

Expedited Clinical Appeals

Appeal Process	Time Period
Prior to an authorization for a current course of treatment or continued hospitalization is terminated or reduced, we will send you a notice giving you an opportunity to appeal.	During the review process, coverage for the ongoing course of treatment will continue.

Concurrent Clinical appeal or Pre-Service appeal	Within 24 hours of the appeal's receipt, we will tell you if more information is needed to complete our review. Within 24 to 72 hours, depending on the immediacy of the condition, we will let you know our decision.

How to Appeal an Adverse Benefit Determination

If you believe we incorrectly denied all or part of your claim for **benefits**, you may have your claim reviewed. Your request for us to review an adverse determination is an appeal of an adverse determination.

You, or an authorized representative, may act on your behalf, and file an adverse benefit determination appeal. In some circumstances, your **provider** may appeal on your behalf. If you choose an authorized representative, we must be notified in writing. To obtain an Authorized Representative Form, you, or your authorized representative may call us at the toll-free telephone number on the back of your **identification card.**

You must file an appeal within 180 calendar days from the time you receive a notice of an **adverse benefit determination**. You may call us at the toll-free telephone number on the back of your **identification card**, with your reason for making the appeal; or send your written appeal to:

Appeal Coordinator – Customer Service Department
Blue Cross and Blue Shield of Oklahoma
PO Box 655924
Dallas, Texas 75265-5924

The review of our decision will take place as follows:

Appeal Process	Time Period
You may present evidence and testimony in support of your claim.	Within 180 calendar days or during the review process
You may review your claim file and relevant documents. You may submit written issues, comments, and additional medical information.	Within 180 calendar days or during the review process
We will give you any new or additional information we use to review your claim before the date a final decision on the appeal is made.	Within 180 calendar days or during the review process
The review and decision of your appeal will be made by personnel not involved in making the initial adverse decision.	During the review process

Appeal Process	Time Period
If the initial adverse decision was based on a medical result, the review will be made by a **physician** associated or contracted with us, and/or by external advisors, who were not involved in the initial adverse benefit determination.	During the review process
We will not consider the initial adverse benefit determination.	During the review process
Non-urgent concurrent or pre-service appeal, within	30 days upon receipt of the appeal
Post-service appeal, within	60 days upon receipt of the appeal or 30 days if the determination involves **medical necessity** or **experimental/investigational**

Please note: This appeal process does not prohibit you from pursuing a civil action under the law.

If you have a claim for **benefits** which is denied or ignored, in whole or in part, and your **plan** is governed by the Employee Retirement Income Security Act (ERISA), you may file suit under 502 (a) of ERISA.

If You Need Assistance

If you have any questions about claims procedures or review procedures, please call us at the toll-free telephone number on the back of your **identification card**. Our Customer Service helpline is available from 8:00 A.M. to 6:00 P.M. Monday through Friday, or write to us at:

Claim Review Section
Blue Cross and Blue Shield of Oklahoma
P O Box 655924
Dallas, TX 75265-5924

Notice of Appeal Determination

We will provide a written notice of our appeal determination to you, and, if your appeal is a clinical appeal, to the **provider** who recommended the services involved in the appeal.

The written notice to you includes:

- The reasons for the determination, including the guidelines used in denying the claim and a discussion of the decision, benefit **plan** provisions, contractual, administrative, or procedure basis.
- The identification of the claim, date of service, health care **provider**, claim amount (if applicable), and a statement describing denial codes with their meanings and the standards used - subject to privacy laws and other restrictions, if any. Upon request, diagnosis/treatment codes with their meanings and the standards used.
- An explanation of our external review processes (and how to initiate an external review)and a statement of your right, if any, to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act (ERISA) following a final denial on external appeal.

- If available, and upon request, a document in non-English language(s) showing how to access the language services provided by us, including a written notice of claim denials and certain other benefit information.
- The right to request, without any cost to you, reasonable access to, and copies of, all documents, records, and other information related to the claim for **benefits**.
- Any internal rule, guideline, procedure, or other similar reasons relied upon in the determination, and instructions on getting a copy of these, upon request, without any cost to you.
- An explanation of the scientific or clinical decision relied upon in the determination, or instructions on getting a copy of the explanation, upon request, without any cost to you.
- Health Insurance Consumer Assistance or Ombudsman contact information (as appropriate).

If we deny your appeal, in whole or in part, or you do not receive a timely decision, you may request an external review of your claim by an independent third party, who will review the denial and issue a final decision. Your external review rights are described below under the **How to Appeal a Final Internal Adverse Determination to an Independent Review Organization (IRO)** section.

How to Appeal a Final Internal Adverse Determination to an Independent Review Organization (IRO)

An independent review is a review made by an organization independent of us. This is called an independent review organization (IRO).

IRO Procedures and Definitions

Adverse Benefit Determination means our determination, or our designated utilization review organization, that the admission, availability of care, continued stay, or other covered service has been reviewed and determined to be, or meet requirements for:

- Experimental/ investigational.
- Medically necessity, appropriateness, health care setting, level of care, or effectiveness.

An adverse determination includes the denial, reduction, or termination of a requested service.

Final internal adverse benefit determination means an adverse benefit determination that we confirmed after completing our internal review/appeal process.

You are entitled to an immediate appeal to an IRO if your request is based on the following:

- Life-threatening, urgent care circumstances.
- If you were receiving prescription **drugs** or intravenous infusions and coverage was discontinued.

You are not required to comply with our appeal of an adverse determination process if an immediate appeal to an IRO is requested.

If we deny your appeal of an adverse determination, you, your authorized representative, or **provider** may seek review of the decision by an IRO. We will send you a notice of adverse determination and describe the independent review process, including a copy of the request for an independent review form.

You must submit the request for independent review form to us within four (4) months after receipt of the adverse determination.

In life-threatening, **urgent care** situations, denial of a step therapy exception request, or if you were receiving **prescription drugs** or intravenous infusions and coverage was discontinued you, your authorized representative, or **provider** may contact us by telephone to request the review and provide the required information.

- We will submit medical records, names of **providers**, and documentation related to the decision of the IRO.
- We will comply with the decision by the IRO.
- We will pay for the independent review.

Upon request and without any cost to you, you or your authorized representative may have reasonable access to, and copies of, all documents, records, and other information regarding the claim or appeal, including:

- Information relied upon to make the decision.
- Information submitted, considered, or generated while making the decision, and whether it was relied upon.
- Descriptions of the administrative process and safeguards used to make the decision.
- Records of any independent reviews conducted by us.
- Medical judgments, including whether a particular service is **experimental/investigational** or not **medically necessary** or appropriate.
- Expert advice and consultation obtained by us in connection with the denied claim, whether the advice was relied upon to make the decision.

If the process for appeal and review places your health in serious jeopardy, you are not prohibited from pursuing other appropriate remedies under the law, including, injunctive relief, a declaratory judgment, or other relief If your **plan** is governed by the Employee Retirement Income Security Act (ERISA), you have the right to bring a civil action under 502(a) of ERISA.

If You Need Assistance

If you need assistance with the internal claims and appeals or the external review processes, please call the toll-free telephone number on the back of your **identification card** for contact information. In addition, for questions about your appeal rights or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

Actions Against Us

No lawsuit, or action in law, or equity, may be brought by you, or on your behalf, before the expiration of 60 days after a **proof of loss** has been filed in agreement with **plan** requirements; and no such action will be brought unless it is brought within three years after the expiration of 60 days when a **proof of loss** has been filed.

For additional information and claim forms, please visit www.BCBSOK.com.

Please Mail Completed Claim Forms to:

Medical Claims	**Prescription Drug Claims**
Blue Cross and Blue Shield of Oklahoma Claims Division PO Box 655924 Dallas, TX 75265-5924	Prime Therapeutics LLC P.O. Box 25136 Lehigh Valley, PA 18002-5136

In addition to the **GLOSSARY** section of this benefit booklet, the following definitions apply to this section:

Concurrent Care Claim means a claim occurs when you need us to approve more services than we already have approved. Examples are extending a **hospital** stay or adding visits to a **provider**. We will notify you of our determination for such a request within 24 hours after receipt of your claim for **benefits**.

GENERAL PROVISIONS

This section includes:

- The **benefits** you are qualified to receive.
- How to get **benefits.**
- Your relationship with **hospitals**, **physicians** and **other providers.**
- Your relationship with us.
- Coordination of **benefits** when you have other coverage and reimbursement.
- Termination of coverage with us.
- Continuation of **group** coverage.

Amendments

We and your **employer** may agree to amend or change the **plan** at any time. We must provide notice of any material modification (as defined under section 102 of ERISA) to you and your **dependents** not later than 60 days before the modification's **effective date**. We must provide this notice for any material modification of any of the **plan** terms of the **plan** or **plan** coverage that affects the content of the most recent **Summary of Benefits and Coverage** (SBC) and that occurs other than in connection with a renewal or reissuance of coverage. **The Summary of Benefits and Coverage** (SBC) is a document that summarizes **plan benefits**, cost-sharing, and limitations, as required under the Affordable Care Act.

Assignment and Payment of Benefits

If a written assignment of **benefits** is made by you or your **dependents** to a **provider** and the written assignment is delivered to us with the claim for **benefits**, we will make any payment directly to the **provider**. Payment to the **provider** discharges our responsibility to you and your **dependents** for any **benefits** available under the **plan**.

You cannot assign your right to receive payment to anyone else, either before or after **covered services** are received, except as permitted by applicable law.

Once a **provider** performs a **covered service**, the **plan** will not honor a request not to pay the claims submitted.

Benefits under this Certificate will be based upon the **allowable charge** (as we determine) for **covered services**. An **in-network provider** may collect any **deductible**, and **copayment** and/or **coinsurance** amounts applicable to your coverage, but you will not be responsible for any amounts that exceed the **allowable charge** for **covered services**.

However, if you receive covered services from an out-of-network provider, you may be responsible for amounts which exceed the allowable charge, in addition to any deductible, and copayment and/or coinsurance amounts which may apply.

THE BLUECARD® PROGRAM

The BlueCard® Program allows you to use a Blue Cross and Blue Shield participating **physician** or **hospital** outside the state of Oklahoma and to receive the advantages of **network provider benefits** and savings.

Under the BlueCard® Program, when you access **covered services** within the geographic area served by a Host Blue, we will remain responsible for what we agreed to in the contract. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare **providers.**

For **inpatient** facility services received in a **hospital**, the Host Blue's Participating **provider** is required to obtain **prior authorization**. If **prior authorization** is not obtained, the **participating provider** will be sanctioned based on the Host Blue's contractual agreement with the **provider**, and the **member** will be held harmless for the **provider** sanction.

Whenever you receive **covered services** outside the **plan's service area** and the claim is processed through the BlueCard® Program, the amount you pay for covered healthcare services is calculated based on the lower of:

- The billed covered charges for your **covered services**; or
- The negotiated price that the Host Blue makes available to the **plan**.

To help you understand how this calculation would work, please consider the following example:

- Suppose you receive **covered services** for an illness while you are on vacation outside of Oklahoma. You show **your identification card** to the **provider** to let him or her know that you are covered by the **plan**.
- The **provider** has negotiated with the Host Blue a price of $80, even though the **provider's** standard charge for this service is $100. In this example, the **provider** bills the Host Blue $100.
- The Host Blue, in turn, forwards the claim to the **plan** and indicates that the negotiated price for the **covered service** is $80. The **plan** would then base the amount you must pay for the service - the amount applied to your **deductible**, if any, and your **coinsurance** percentage - on the $80 negotiated price, not the $100 **billed charge**.
- So, for example, if your **coinsurance** is 20%, you would pay $16 (20% of $80), not $20 (20% of $100). You are not responsible for amounts over the negotiated price for a **covered service**.

Finding a Physician or Hospital:

When you're outside of Oklahoma and you need to find information about a Blue Cross and Blue Shield **physician** or **hospital**, just call the BlueCard Doctor and Hospital Information Line at 1-800-810-BLUE (2583), or you may refer to the BlueCard Doctor and Hospital Finder at www.bcbsok.com They will help you locate the nearest participating **physician** or **hospital**. Remember, you are responsible for receiving, if applicable, from Blue Cross and Blue Shield of Oklahoma. As always, in case of an emergency, you should seek immediate care from the closest health care **provider**.

Available Care Coast to Coast

Show your **identification card** to any Blue Cross and Blue Shield **physician** or **hospital** across the USA. The participating **physicians** and **hospitals** can verify your membership eligibility and coverage with Blue Cross and Blue Shield of Oklahoma and submit your claims for you.

Remember to Always Carry the BlueCard

Make sure you always carry your **identification card** –The BlueCard. And be sure to use Blue Cross and Blue Shield **physicians** and **hospitals** whenever you are outside the state of Oklahoma and need health care.

Some local variations in **benefits** do apply. If you need more information, call Blue Cross and Blue Shield of Oklahoma today.

NOTE: We may postpone application of any **deductible**, **copayment** and/or **coinsurance** amounts whenever it is necessary in order to obtain **provider** discounts for **covered services** you receive outside the state of Oklahoma.

Benefits You Are Qualified to Receive

We supply only the **benefits** specified in this **benefit booklet**. Only you and your **dependents** may receive **benefits** from us. You and your **dependents** may not transfer your rights to **benefits** to anyone else.

Benefits for **covered services** specified in this **benefit booklet** will be covered only for those **providers** specified in this **benefit booklet**.

Complying with State Statutes

Laws in some states require that certain **benefits** or provisions be provided to you if you are a resident of that state and the **contract** that insures you is not issued in your state.

Any **benefit** or provision of this benefit booklet which conflicts with applicable statutes of the state the **employee** lives, on the **effective date** of the benefit booklet, will be amended to comply to:

- The minimum requirements of the applicable statutes, or
- The **benefits** or provisions of this benefit booklet to the extent they exceed the minimum requirements.

Disclosure Authorization

If you file a claim for **benefits**, you must authorize any health care **provider**, insurance company, or other entity to provide us all information and records or copies of records relating to you or your **dependent's** diagnosis, treatment, or care. If you file claims for **benefits**, you and your **dependents** will be considered to have waived all requirements forbidding the disclosure of this information and records.

Entire Contract

The entire **contract** is made up of a **plan**, including the agreement between Blue Cross and Blue Shield and the **group**, any addenda, this **benefit booklet**, along with any exhibits, appendices, addenda and/or other required information, and the individual application(s) of the persons covered under the **certificate**, **benefit** and premium notification documents, if any, and rate summary documents, if any. All statements contained in the application will be considered representations and not warranties. No such statements will be used to void the insurance, reduce the **benefits**, or be used in defense of a claim for loss incurred unless it is contained in a written application.

No agent has the authority to change or waive any part of the **plan**, to extend the time for payment of premiums, or to waive any of the rights or requirements of BCBSOK. No modifications of the **plan** will be valid unless shown by an endorsement or amendment of the **plan**, signed by an officer of BCBSOK and delivered to your **group**.

Identity Theft Protection

Identify theft protection services are available to you at no additional cost.

The identity theft protection services include:

- Credit monitoring.
- Fraud detection.
- Credit/identity repair.
- Insurance to help protect your information.

These identity theft protection services are currently provided by BCBSOK's chosen outside vendor. Accepting or declining these services is optional for you and your **dependents**.

You may accept identity theft protection services by enrolling in the program online at www.bcbsok.com or by calling the telephone number on the back of your **identification card**.

Services may automatically end when the person is no longer an eligible **participant**. Services may change or be stopped at any time with reasonable notice. We do not guarantee that a particular vendor or service will be available at any given time.

Limitations on Plan's Right of Recoupment/Recovery

We will not seek recovery of all or a portion of a payment of a claim made to you more than six (6) months or a provider more than twelve (12) months after the payment is made. This paragraph shall not apply:

- If the payment was made because of fraud committed by you or the **provider**; or
- If you or a **provider** has otherwise agreed to make a refund to the **plan** for overpayment of a claim.

Member Data Sharing

You may apply for and receive replacement coverage under certain circumstances like from involuntary termination of your health coverage sponsored by the **group**/**employer**.

The replacement coverage will be coverage offered by us. If you do not live in the **service area**, coverage will be offered by the Blue Cross and/or Blue Shield Plan whose **service area** covers the geographic area where you live.

As part of the **benefits** that we offer you, if you do not live in the **service area**, we may assist you in applying for and getting such replacement coverage, subject to applicable eligibility requirements, from the Blue Cross and/or Blue Shield Plan available in the **service area** in which you live.

To do this we may:

- Contact you directly and/or
- Provide the Blue Cross and/or Blue Shield Plan whose **service area** covers the geographic area where you live, with your personal information and other general information relating to your coverage under this **plan.** Only your necessary information will be provided to prepare the appropriate Blue Cross and/or Blue Shield Plan to offer you uninterrupted coverage through replacement coverage.

Member Rewards Medical

Member Rewards is a free, program that you can choose that eligible **participants** can earn a percentage of the claim savings in a cash reward by selecting quality, low-cost **network** facilities for qualified elective, non-emergency medical services. **Participants** can use the Provider Finder tool on our website at www.bcbsok.com/find-a-doctor-or-hospital to find a list of all eligible services and facility options. Shopping

can also be done by calling the number on the back of your insurance **identification card**, who will shop for services and facilities for you.

When you choose a rewards eligible service, you will earn a part of the savings in the form of a check mailed to you, usually within 60 days. This reward is separate from and does not affect your claim for a qualified service. To earn a reward, you must:

- Have active coverage on the date you shop for a rewards-eligible service.
- Have active coverage on the date the medical service is given.
- Complete the rewards-eligible service within thirteen months of shopping.

Cash reward amounts and eligible services are subject to change; however, the maximum reward amount you may earn on any single procedure is $500. Any reward amounts received may be taxable.

Your **provider** may refer you to a facility or location to complete your medical service or procedure not eligible for a reward. However, you must use a facility that is eligible for the program to receive a reward. If your **provider** refers you to a facility that is not eligible for a reward under the program, customer service may be able to work with your **provider** to find an eligible facility or location, if one is available. Remember, all decisions on where to receive care are between you and your **provider**.

Member Rewards is not a discount program and will not change **benefits** or claims processing. The **plan** may stop or change this program upon 180 days' notice to **participants**. To keep eligibility for a reward, you must complete shopping for a rewards-eligible service prior to the program termination following a program termination notice. Rewards may be paid out up to 90 days after program termination. All rewards earned under this program will be funded by us, and subject to the provided provisions of this program and all other applicable articles of coverage including payment of **benefits**, termination of coverage, and review of claim determinations. A referral or **prior authorization** may be needed for your procedure or service.

If you have questions about this program, call customer service or visit our website at www.bcbsok.com.

Participant/Provider Relationship

The choice of a health care **provider** should be made by you or your **dependents**.

The **claim administrator**:

- Does not provide services or supplies but only pay for eligible expenses incurred by you or your **dependents**.
- Is not liable for any act or omission by any health care **provider**.
- Does not have any responsibility for a health care **provider's** failure or refusal to provide services or supplies to you or your **dependents**.

The selected health care **provider** has rules and regulations that apply to care, and treatment received by you or your **dependents.** The care and treatment are available only for sickness or injury treatment acceptable to the health care **provider**.

We, **in-network providers**, and/or other contracting **providers** are independent contractors concerning each other. We in no way control, influence, or take part in the health care treatment decisions by **providers**. We do not give medical, surgical, hospitalization, or similar services or supplies, or practice medicine or treat patients.

The **providers**, their **employees**, their agents, their ostensible agents, and/or their representatives do not act on behalf of us nor are they our **employees**.

Refund of Benefit Payments

- Your **group**'s **plan** and the **claim administrator** have the right to receive a refund of an **overpayment** from:
- The person to, or for whom, such **benefits** were paid.
- Any insurance company or **plan**.
- Any other persons, entities, or organizations, including, but not limited to, **in-network providers** or **out-of-network providers.**

If no refund is received, we (in our capacity as insurer or administrator) and/or your **group's benefit plan** have the right to deduct any refund for any **overpayment** due, up to an amount equal to the **overpayment**, from:

- Any future **benefit** payment made to any person or entity under this **benefit booklet**, even if it is for the same or a different **participant.**
- Any future benefit payment made to any person or entity under another BCBSOK-administered ASO benefit **plan** and/or BCBSOK-administered insured benefit **plan** or policy.
- Any future benefit payment made to any person or entity under another BCBSOK-insured **group** benefit **plan** or individual policy.
- Any future **benefit** payment, or other payment, made to any person or entity.
- Any future payment owed to one or more participating **providers** or **out-of-network providers.**

Further, we have the right to reduce your **benefit plan's** or policy's payment to a **provider** by the amount necessary to recover another BCBSOK **plan's** or policy's overpayment to the same **provider** and to pay the recovered amount to the other BCBSOK **plan** or policy.

Right of Reimbursement

In areas where subrogation rights are not recognized, or where subrogation rights are ruled out by factual circumstances, we will have a right of reimbursement.

If you or your **dependent** receive money from any person, organization, or insurer for an injury or condition for which we paid **benefits** under this **plan**, you or your **dependent** agree to reimburse us from the money received for the amount of **benefits** paid or provided by us. That means you or your **dependent** will pay us the amount of money received by you through judgment, settlement or otherwise from the third party or their insurer, as well as from any person, organization or insurer, up to the amount of **benefits** paid or provided by us.

Right to Recovery by Subrogation or Reimbursement

You or your **dependent** agree to promptly give us all information which you have concerning your rights of recovery from any person, organization, or insurer and to help us protect and obtain our reimbursement and subrogation rights. You, your **dependen**t or your attorney will notify us before settling any claim or suit to allow us to enforce our rights by taking part in the settlement of the claim or suit. You or your **dependent** further agree not to allow our reimbursement and subrogation rights to be limited or harmed by any acts or failure to act on your part.

Subrogation

In this Subrogation section, **subrogation** means the substitution of one person or entity (BCBSOK) in the place of another (you or your **dependent**) with reference to a lawful claim, demand or right, so that whoever is substituted succeeds to the rights of the other in relation to the debt or claim, and its rights or remedies.

If we pay or provide **benefits** for you or your **dependents** under this **plan**, we are subrogated to all rights of recovery which you or your **dependent** have in **contract**, tort, or otherwise against any person, organization, or insurer for the amount of **benefits** we have paid or provided. That means we may use your rights to recover money through judgment, settlement, or otherwise from any person, organization, or insurer.

Value Based Programs

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

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

Contact the **plan** for additional information regarding any **Value Based Programs** available to you.

Coordination Of Benefits And Reimbursement

NOTE: If your Group purchased this coverage in conjunction with a Health Savings Account, this *Coordination of Benefits* section does not apply to you.

All **benefits** provided under this **plan** are subject to this provision.

Other Coverage under specific benefit arrangements, such as dental care or vision care benefit **plans** that are not part of a comprehensive health care benefit **plan**, shall be excluded from the definition of "Other Contract" herein.

Effect On Benefits

If the total **benefits** for **covered services** to which you would be entitled under the **plan** and all other contracts exceed the **covered services** you receive in any **benefit period,** then the **benefits** the **plan** provides for that **benefit period** will be determined according to this provision.

When the **plan** is primary, the **plan** will pay **benefits** for **covered services** without regard to your coverage under any other contract.

When the plan is secondary, the benefits the plan provides for covered services may be reduced because of benefits received from the other contracts.

Order of Benefit Determination

- When a person who received care is covered as an employee under one **group contract**, and as a **dependent** under another, then the employee coverage pays first.
- When a **dependent child** is covered under two **group contracts**, the contract covering the **child** as a **dependent** of the parent whose birthday falls earlier in the **calendar year** pays first. (If one contract does not follow the "birthday rule" provision, then the rule followed by that **contract** 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 you have had for the longest time pays first, except that a contract which covers you as a laid-off or retired employee or as a **dependent** of such person pays after a contract which covers you as other than a laid-off or retired employee or **dependent** of such person.

When the **plan** requests information from another carrier to determine the extent or order of your **benefits** under another contract, and such information is not furnished after a reasonable time, then the **plan** shall:

- Assume the **other contract** is required to determine its **benefits** first;
- Assume the **benefits** of the **other contract** are identical to the **benefits** of this coverage and pay its **benefits** accordingly.

Once the **plan** receives the necessary information to determine your **benefits** under the **other contract** 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 carrier reduces your **benefits** because of payment you received under this coverage and the above rules do not allow such reduction, then the **plan** will advance the remainder of its full **benefits** under this coverage as if your **benefits** had been determined in absence of an **other contract**. **However, the plan shall be subrogated to all of your rights under the other contract.** You must furnish all information reasonably required by the Plan in such event, and you must cooperate and assist the **plan** in recovery of such sums from the other carrier.

- If the other carrier later provides **benefits** to you for which the **plan** has made payments or advances under this **COORDINATION OF BENEFITS** provision, you must hold all such payments in trust for the **plan** and must pay such amount to the **plan** upon receipt.

Facility of Payment

If payment is made under another benefit **plan** which we should have made under this provision, then we have the right to pay whoever paid under the **plan** the amount we determine is necessary under this provision. Amounts so paid are **benefits** under the **contract** and we are discharged from liability to the extent of such amounts paid for **covered services**.

Right of Recovery

If we pay more for **covered services** than this provision requires, we have the right to recover the excess from anyone to or for whom the payment was made. You agree to do whatever is necessary to secure our right to recover the excess payment.

Termination of Coverage

Termination of Individual Coverage

Coverage under this **plan** for you and/or your **dependents** will automatically end when:

- Your part of the **group** premium is not received promptly by us.
- You no longer satisfy the definition of an **employee** as defined in this **benefit booklet**, including termination of employment.
- The **plan** is ended, or the **plan** is amended, at the direction of the **employer**, to end the coverage of the class of **employees** to which you belong.
- A **dependent** ceases to be a **dependent** as defined in the **plan**.

However, when any of these events occur, you and/or your **dependents** may be eligible for continued coverage. See **Continuation Privilege** in the **GENERAL PROVISIONS** section of this **benefit booklet**.

We may refuse to renew the coverage of an **eligible person** or **dependent** for fraud or intentional misrepresentation of a material fact by that individual.

Coverage for a **child** of any age who is medically certified as **disabled** and **dependent** on the parent will not end upon reaching the limiting age shown in the definition of **dependent** if the **child** continues to be both:

- Disabled.
- Dependent upon you for more than one-half of their support as defined by the Internal Revenue Code of the United States.

Termination of the Group

The coverage of all **participants** will end if the **group** is stopped in accordance with the terms of the **plan**.

In addition to the **GLOSSARY** section of this benefit booklet, the following definitions apply to this section:

Other Contract means any arrangement, except as specified below, providing health care **benefits** or services through:

- **Group**, **group**-type, non-**group**, individual, blanket or franchise insurance coverage.
- Blue Cross Plan, Blue Shield Plan, Health Maintenance Organization and other prepayment coverage.
- Coverage under labor-management trusteed **plans**, union welfare **plans**, e**mployer** organization **plans** or **employee** benefit organization **plans.**
- Coverage toward the cost of which any **employer** has contributed, or with respect to which any **employer** has made payroll deduction.
- **Group** or individual automobile insurance coverage and
- Coverage under any tax supported or government program, including Medicare, 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 contract covering the person for whom claim is made or service provided.

Dependent additionally means a person who qualifies as a **dependent** under another contract.

Overpayment means when we or your **group's benefit plan** pay **benefits** for eligible expenses received by your or your **dependents** and it is found that the payment was more than it should have been or was made by mistake.

Employee Retirement Income Security Act Of 1974 (ERISA)

As a **participant** in this **group health plan**, you may be entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA).

- If the health **benefit plan** is part of an "**employee** welfare **benefits plan**" and "welfare **plan**" as those terms are defined in ERISA:
- The **plan administrator** will furnish summary **plan** descriptions, annual reports, and summary annual reports to you and other **plan participants** and to the government as required by ERISA and its regulations.
- We will furnish the **plan administrator** with this benefit booklet as a description of **benefits** available under this health **benefit plan**. Upon written request by the **plan administrator**, we will send any information which the **claims administrator** has that will aid the **plan administrator** in making its annual reports.
- Claims for **benefits** must be made in writing on a timely basis in accordance with the provisions of this health **benefit plan**. Claim filing and claim review health procedures are found in the **CLAIM FILING AND APPEALS PROCEDURES** section of this benefit booklet.
- Blue Cross and Blue Shield of Oklahoma, as the **claims administrator** is not the ERISA "**plan administrator**" for **benefits** or activities pertaining to the health **benefit plan**.
- This benefit booklet is not a summary **plan** description.

The **plan administrator** has given the **claims administrator** the authority and discretion to interpret the **health benefit plan** provisions and to make eligibility and **benefit** determination. The **plan administrator** has full and complete authority and discretion to make decisions regarding the health **benefit plan's** provisions and determining questions of eligibility and **benefits**. Any decisions made by the **plan administrator** shall be final and conclusive

GLOSSARY

Allowable Amount or **Allowed Amount** means the maximum amount determined by us to be eligible for consideration of payment for a particular **covered service**, covered supply and **covered drug**. Your **deductible**, **coinsurance** and **copayment** are based on the **allowable amount** and the terms of your **plan**. Your share of **coinsurance** is a percentage of the **allowable amount** after the **deductible** is met.

Ambulatory Surgical Facility means a provider with an organized staff of physicians which:

- Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis
- Provides treatment by or under the supervision of **physicians** and nursing services whenever the patient is in the facility
- Does not provide Inpatient accommodations; and

Is not, other than incidentally, a facility used as an office or clinic for the private practice of a **physician** or **other provider**

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

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

Behavioral Health Provider means a **physician** or **other professional provider** who renders services for mental and **behavioral health** conditions or **substance use disorder** and is operating within the scope of such license.

Benefits mean the payment, reimbursement and indemnification of any kind which you will receive from and through the **plan** under this **contract**.

Benefit Period means the period during which you receive **covered services** for which the **plan** will provide **benefits**.

Billed Charge means the total amount a provider charges for a service or item that is billed.

Brand Name Drug means a drug or product manufactured by a single manufacturer as defined by a nationally recognized **provider** of drug product database information. There may be some cases where multiple manufacturers will produce the same product under one license, known as a co-licensed product, which would also be considered as a **brand name drug**. There may also be situations where a drug's classification changes from generic to brand name due to a change in the market resulting in the generic being a single source, or the drug product database information changing, which would also result in a corresponding change in **copayment** obligations from generic to brand name.

Brand Name Drug (Non-Preferred) means a **brand name** prescription **drug** which appears on the applicable **drug list** as a non-preferred **brand name drug** and has not been designation by the **plan** as a preferred **brand name drug** and is subject to **copayment** and/or c**oinsurance** amount designated in the **SUMMARY OF BENEFITS**. You can access this **drug list** at www.bcbsok.com.

Brand Name Drug (Preferred) means a **brand name** prescription **drug** which appears on the **drug list** as a preferred **brand name drug** and has been designated by the **plan** to be part of its preferred prescription drug program and is subject to the **copayment** and/or **coinsurance** amount designated in the **SUMMARY OF BENEFITS**. This list is available by accessing the website at www.bcbsok.com.

Calendar Year means the 12 month period commencing on January 1 and ending on the next succeeding December 31, inclusive.

Claims Administrator means Blue Cross and Blue Shield of Oklahoma (BCBSOK).

COBRA Continuation Coverage means coverage under the group contract for you and your eligible dependent with respect to whom a **qualifying event** has occurred, and consisting of coverage which, as of the time the coverage is being provided, is identical to the coverage provided under the contract to subscribers to whom a **qualifying event** has not occurred.

Coinsurance means the percentage of the allowed amount you pay as your share of the bill. For example, if your **plan** pays 80% of the allowed amount, 20% would be your **coinsurance.**

Contract/Group Contract means your **employer** issued group benefits contract.

Copayment (Copays) means the set amount you pay each time you receive a certain service.

Covered Drugs means any prescription drug:

- Which is included on the applicable **drug list**
- Which is **medically necessary** and is ordered by an authorized **provider** for you or your **dependent**
- Which is not consumed at the time and place that the **prescription order** is written
- For which the FDA has given approval for at least one indication
- Which is dispensed by a **pharmacy** and you received while covered under the **plan**, except when received from a **provider's** office, or during confinement while a patient in a **hospital** or other acute care institution or facility (refer to **Limitations and Exclusions**)

Covered Person means the member and each of their **dependents** (if any) covered under this **plan**.

Covered Services mean a service or supply shown in this **certificate** for which **benefits** will be provided.

Custodial Care means any service primarily for personal comfort for convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of your condition.

- **Custodial Care** services also means those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel to be safely

and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (e.g. simple care and dressings, administration of routine drugs, etc.) and are to assist with activities of daily living (e.g. bathing, eating, dressing, etc.).

Deductible means the amount, if any, you must pay before we start paying **contract benefits**. You do not send this amount to us. We subtract this amount from covered expenses on claims you and health care professionals send us. Some services can be covered before the **deductible** is met. Refer to your **SUMMARY OF BENEFITS** for any **deductibles** applicable to your coverage.

Dependent means your spouse or **domestic partner** (provided your **employer** covers **domestic partners**) or any **child** covered under the **plan**.

Child means a:

- Natural **child**
- A step**child**
- A foster **child**
- An adopted **child** including those placed with you for adoption

A **child** must also be under twenty-six (26) years of age, regardless of:

- Financial dependency
- Residency
- Student status
- Employment status
- Marital status

Disabled means any medically determinable physical or mental condition that prevents the **child** from engaging in self-sustaining employment. The disability must begin while the **child** is covered under the **plan** and before the **child** reaches the limiting age. You must give satisfactory proof of the disability and dependency through your **employer** to us within 31 days following the **child's** attainment of the limiting age. As a condition to the continued coverage of a **child** as a **disabled dependent** beyond the limiting age, we may require periodic certification of the **child's** physical or mental condition but not more often than annually after the two-year period following the **child's** attainment of the limiting age.

Domestic Partner means a person with whom you have entered into a **domestic partnership** in accordance with the **employer's** guidelines.

Note*:* **Domestic partner** coverage is available at your **employer's** discretion. Contact your **employer** for information on whether **domestic partner** coverage is available under your **plan**.

Note: A **domestic partner** is not recognized as a spouse for certain federally regulated programs, such as COBRA Continuation Coverage and Medicare.

Domestic Partnership means long-term committed relationship of indefinite duration with a person which meets the following criteria:

- You and your **domestic partner** have lived together for at least 6-18 months;
- Neither you nor your **domestic partner** is married to anyone else or has another **domestic partner**;
- Your **domestic partner** is at least 18 years of age and mentally competent to consent to **contract**;
- Your **domestic partner** resides with you and intends to do so indefinitely;
- You and your **domestic partner** have an exclusive mutual commitment similar to marriage; and
- You and your **domestic partner** are jointly responsible for each other's common welfare and share financial obligations.

Drug List means a list of drugs that may be covered under the **PHARMACY BENEFITS** portion of the **plan**. This list is available by accessing the website at www.bcbsok.com. You may also contact Customer Service at the toll-free number on your **identification card** for more information.

Effective Date means the date the coverage for a **participant** begins.

Emergency Care means health care services provided in a **hospital** emergency facility (emergency room), freestanding emergency medical care facility, or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that the person's condition, sickness, or injury is of such a nature that failure to get immediate care could result in:

- Placing the patient's health in serious jeopardy
- Serious impairment of bodily functions
- Serious dysfunction of any bodily organ or part
- Serious disfigurement; or
- In the case of a pregnant individual, serious jeopardy to the health of the fetus

Employee means an individual employed by a group/**employer**. For purposes of this **plan**, the term **employee** will also include those individuals who are no longer an **employee** of the **employer**, but who are **participants** covered under the Consolidated Omnibus Budget Reconciliation Act (COBRA) or continued under the appropriate provisions of the Oklahoma Insurance Code.

If applicable to your **plan**, **employees** who have retired under the large **employer's** established procedures whether by either individual selection by the **employer** or the **employee** to be included in a retiree classification, may continue coverage under this **contract**.

Employer means a **group**, as defined, in which there exists an employment relationship between a **participant** and the **group**.

Experimental/Investigational means the use of any treatment, procedure, facility, equipment, drug, device, or supply (including emerging technologies, services, procedures, and service paradigms) not accepted as *standard medical treatment* of the condition being treated and any of such items requiring Federal or other governmental agency approval not granted at the time services were provided. Approval by a Federal agency means that the treatment, procedure, facility, equipment, drug, device or supply has been approved for the condition being treated and, in the case of a drug, in the dosage used on the patient. Approval by a federal agency will be taken into consideration by us in assessing **experimental/investigational** status but will not be determinative. **Prescription drugs** that are approved by the FDA through the accelerated approval

program may be considered **experimental/investigational**.

As used herein, medical treatment includes medical, surgical, or dental treatment.

Standard medical treatment means the services or supplies that are in general use in the medical community in the United States, and:

- Have been demonstrated in peer reviewed literature to have scientifically established medical value for curing or alleviating the condition being treated.
- Are appropriate for the **hospital** or **other provider** in which they were performed.
- The **physician** or **other professional provider** has had the appropriate training and experience to provide the treatment or procedure.

The medical staff of BCBSOK shall determine whether any treatment, procedure, facility, equipment, drug, device, new or existing technologies, or supplies are **experimental/investigational**, and will consider factors such as the guidelines and practices of Medicare, Medicaid, or other government-financed programs and approval by a federal agency in making its determination.

Although a **physician** or **other professional provider** may have prescribed treatment, and the services or supplies may have been provided as the treatment of last resort, still may determine such services or supplies to be **experimental/investigational** within this definition. Treatment provided as part of a **clinical trial** or a research study is **experimental/investigational**.

Generic Drug means a drug that has the same active ingredient as a **brand name drug** and is allowed to be produced after the **brand name drug's** patent has expired. In determining the brand or generic classification for **covered drugs** we utilize the generic/brand status assigned by a nationally recognized **provider** of drug product database information. You should know that not all drugs identified as a "generic" by the drug product database, manufacturer, **pharmacy**, or your **provider** will be considered generic by us.

Generic Drug (Non-Preferred) means a **generic drug** which appears on the applicable **drug list** as a **non-preferred generic drug**. The **drug list** is available by accessing the website at www.bcbsok.com.

Generic Drug (Preferred) means a **generic drug** which appears on the applicable **drug list** as a **preferred generic drug**. The **drug list** is available by accessing the website at www.bcbsok.com.

Group means classification of coverage whereby a corporation, **employer** or other legal entity has agreed to establish a premium collection and payment system in order to provide an opportunity for its **employees** to acquire **plan** coverage for health care expenses.

Group Health Care Plan means a **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.

Hospital means a short-term acute care facility which:

- Is duly licensed as a **hospital** by the state in which it is located and meets the standards established for such licensing, and is either accredited by the The Joint Commission or is certified as a **hospital** provider under Medicare

- Is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of **physicians** or **behavioral health providers** for compensation from its patients
- Has organized departments of medicine and major surgery, either on its premises or in facilities available to the **hospital** on a contractual prearranged basis, and maintains clinical records on all patients
- Provides 24-hour nursing services by or under the supervision of a Registered Nurse
- Has in effect a **hospital** utilization review **plan**

Identification Card means the card issued to the **employee** by us indicating pertinent information applicable to their coverage.

Inpatient means a **covered person** who receives care as a registered bed patient in a **hospital** or **other provider** where a room and board charge is made.

In-Network Benefits means the **benefits** available under the **plan** for services and supplies that are provided by an **in-network provider** or an **out-of-network provider** when acknowledged by us.

In-Network Provider means a **hospital**, **physician**, **behavioral health provider** or **other professional provider** who has entered into an agreement with us (and in some instances with other participating Blue Cross and/or Blue Shield Plans) to participate as a managed care **provider**.

Intensive Outpatient Program means a freestanding or **hospital**-based program that provides services for at least 3 hours per day, 2 or more days per week, to treat **mental health or substance use disorder** or specializes in the treatment of co-occurring mental health conditions and substance use disorder. Requirements: Our claims administrator requires that any **mental health and/or substance use disorder intensive outpatient program** must be licensed in the state where it is located, or accredited by a national organization that is recognized by our claims administrator, as set forth in the current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy. **Intensive outpatient program** services may be available with less intensity if you are recovering from severe and/or chronic mental health conditions and/or substance use disorders. If you are recovering from severe and/or chronic mental health conditions and/or substance use disorder, services may include psychotherapy, pharmacotherapy, and other interventions aimed at supporting recovery such as the development of recovery **plans** and advance directives, strategies for identifying and managing early warning signs of relapse, development of self-management skills, and the provision of peer support services. **Intensive outpatient programs** may be used as an initial point of entry into care, as a step up from routine outpatient services, or as a step down from acute inpatient, residential care or a partial hospitalization treatment program.

Legend Drugs mean drugs, biologicals, or compounded prescriptions which are required by law to have a label stating “Caution - Federal Law Prohibits Dispensing Without a Prescription,” and which are approved by the U.S. Food and Drug Administration (FDA) for a particular use or purpose.

Maintenance Prescription Drug means a prescription drug prescribed for chronic conditions and which is taken on a regular basis to treat conditions such as high cholesterol, high blood pressure, or asthma.

Medically Necessary or **Medical Necessity** means those services or supplies covered under the **plan** which are:

- Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of the condition, sickness, disease, injury, or bodily malfunction
- Provided in accordance with and are consistent with generally accepted standards of medical practice in the United States
- Not primarily for the convenience of the **participant**, physician, **behavioral health provider**, the **hospital**, or the **other provider**
- The most economical supplies or levels of service that are appropriate for the safe and effective treatment of the **participant**. When applied to hospitalization, this further means that the **participant** requires acute care as a bed patient due to the nature of the services provided or the **participant's** condition, and the **participant** cannot receive safe or adequate care as an outpatient. We do not determine course of treatment or whether particular health care services are received. The decision regarding the course of treatment and receipt of particular health care services is a matter entirely between the **participant**, **physician**, **behavioral health provider**, the **hospital**, or the **other provider**

If more than one health intervention meets the requirements listed above, **medically necessary** means the most cost effective in terms of type, frequency, extent, site, duration, which is safe and effective for the patient's illness, injury, or disease.

The medical staff of BCBSOK shall determine whether a service or supply is **medically necessary** under the **plan** and will consider the views of the state and national medical communities, the guidelines and practices of Medicare, Medicaid, or other government-financed programs, and peer reviewed literature. Although a **physician**, **behavioral health provider** or **other provider** may have prescribed treatment, such treatment may not be **medically necessary** within this definition.

Medicare means the programs of health care for the aged and disabled established by Title XVIII of the Social Security Act of 1965, as amended.

Network means identified **physicians**, **behavioral health providers**, **other professional providers**, **hospitals**, and other facilities that have entered into agreements with us (and in some instances with other participating Blue Cross and/or Blue Shield Plans) for participation in a managed care arrangement.

Orthognathic Surgery means services or supplies received for correction of deformities of the jaw, including the surgical repositioning of portions of the upper or lower jaws or the bodily repositioning of entire jaws.

Other Provider or Other Facility Provider means a person or entity, other than a hospital or physician, that is licensed where required to furnish to a participant an item of service or supply. **Other provider** shall include:

- Chemical dependency treatment center
- Crisis stabilization unit or facility
- Durable medical equipment **provider**
- Home health agency
- Home infusion therapy **provider**

- Hospice
- Imaging center
- Independent laboratory
- Prosthetics/Orthotics **provider**
- Psychiatric day treatment facility
- Renal dialysis center
- **Residential treatment center**
- Skilled nursing facility
- Therapeutic center

Other Professional Provider - a person or **practitioner**, when acting within the scope of their license and who is appropriately certified, only as listed:

- Advanced practice nurse
- Board certified behavior analyst
- Doctor of chiropractic
- Doctor of dentistry
- Doctor of optometry
- Doctor of podiatry
- Doctor in psychology
- Licensed acupuncturist
- Licensed audiologist
- Licensed chemical dependency counselor
- Licensed dietitian
- Licensed hearing instrument fitter and dispenser
- Licensed marriage and family therapist
- Licensed clinical social worker
- Licensed occupational therapist
- Licensed physical therapist
- Licensed professional counselor
- Licensed speech-language pathologist
- Licensed surgical assistant
- Nurse first assistant
- Physician assistant
- Psychological associates who work under the supervision of a doctor in psychology

Out-of-Network Pharmacy means a pharmacy that has not entered into an agreement with the claims administrator to be a network provider.

Out-of-Network Provider means a hospital, physician, behavioral health provider or other provider who has not entered into an agreement with BCBSOK (or other participating Blue Cross and/or Blue Shield Plan) as a network provider.

Out-of-Pocket-Limit means the total amount of deductibles, copayments, and/or coinsurance which must be satisfied during the benefit period for covered services received from network providers. Once the out-of-pocket limit has been reached, the amount of allowable charges covered by the plan will increase to 100% during the remainder of the benefit period.

Participant means an employee or dependent or a retiree whose coverage has become effective under this contract.

Participating Pharmacy means an independent retail pharmacy, or chain of retail pharmacies, or mail-order pharmacy,or specialty drug pharmacy which has entered into a written agreement with the claims administrator to provide pharmaceutical services to you under the plan.

Participating Pharmacy (Preferred) means participating pharmacy which has a written agreement with the claims administrator to provide pharmaceutical services to covered persons or an entity chosen by the claims administrator to administer its prescription drug program that has been designated as a "preferred participating pharmacy".

To find a preferred participating pharmacy, please refer to the claims administrator's website at www.bcbsok.com or call a Customer Service Representative at the number shown on your identification card.

Participating Specialty Pharmacy means a pharmacy that has entered into an agreement to be a part of the claims administrator's specialty pharmacy network.

Pharmacy means a state and federally licensed establishment that is physically separate and apart from any provider's office, and where legend drugs and devices are dispensed under prescription orders to the general public by a pharmacist licensed to dispense such drugs and devices under the laws of the state.

Pharmacy Vaccine Network means the network of select participating pharmacies which have a written agreement with us to provide certain vaccinations to you under this plan.

Physician means a person, when acting within the scope of their license, who is a Doctor of Medicine or Doctor of Osteopathy. The terms Doctor of Medicine or Doctor of Osteopathy shall have the meaning assigned to them by the state in which they are licensed and operating.

Practitioner means any person holding a valid license to practice medicine and surgery, osteopathic medicine, chiropractic, podiatric medicine, optometry or dentistry, pursuant to the state licensing provisions of Title 59 of the Oklahoma Statutes.

Plan means this self-insured plan of comprehensive health care benefits provided by Blue Cross and Blue Shield of Oklahoma (BCBSOK), a Division of Health Care Service Corporation, a Mutual Legal Reserve

Company, an Independent Licensee of the Blue Cross and Blue Shield Association issued group benefits contract.

Plan Administrator means a named administrator of the Group Health Plan (GHP) having fiduciary responsibility for its operation. BCBSOK is not the Plan Administrator.

Plan Year means the period commencing on the contract date and ending on the day before the next contract date. Please contact your employer for plan year information.

Post-Service Medical Necessity Review means the process of determining coverage after treatment has already occurred and is based on medical necessity guidelines. Can also be referred to as a retrospective review or post-service claims request.

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

Prescription Order means an order from an authorized provider to a pharmacist for a drug or device to be dispensed. Orders by a provider located outside the United States to be dispensed in the United States are not covered under the plan.

Prior Authorization means the process that determines in advance the medical necessity or experimental/investigational nature of certain care and services under this plan.

Proof of Loss means written evidence of a claim including:

- The form on which the claim is made
- Bills and statements reflecting services and items furnished to a participant and amounts charged for those services and items that are covered by the claim
- Correct diagnosis code(s) and procedure code(s) for the services and items

Provider means a **hospital**, **physician**, **behavioral health provider**, **other provider**, or any other person, company, or institution furnishing to a **participant** an item of service or supply.

Provider Incentive mean san additional amount of compensation paid to a health care **provider** by a Blue Cross and/or Blue Shield Plan, based on the **provider's** compliance with agreed-upon procedural and/or outcome measures for a particular population of **covered persons.**

Residential Treatment Center means a facility setting offering a defined course of therapeutic intervention and special programming in a controlled environment which also offers a level of security, supervision, and structure **medically necessary** to meet the needs of patients served or to be served by such facility. To qualify as a **Residential Treatment Center**, patients must be medically monitored with 24-hour medical professional availability and on-site nursing care and supervision for at least one shift a day with on call availability for the other shifts. **Residential Treatment Centers** must be licensed by the appropriate state and local authority as a Residential Treatment Facility or its equivalent under the laws or regulations of such locality and/or must be accredited by a national accrediting body as a **Residential Treatment Center** or its equivalent.

Retail Health Clinic means a **provider** that provides treatment of uncomplicated minor illnesses. **Retail health clinics** are typically located in retail stores and are typically staffed by Advanced Practice Nurses or Physician Assistants.

Service Area means the geographical area or areas specified in the **contract** in which a **network** of **providers** is offered and available and is used to determine eligibility for managed health care **plan benefits**.

Specialty Drugs means prescription drugs generally prescribed for use in limited patient populations or diseases. These drugs are typically injected but may also include drugs that are high cost oral medications and/or that have special storage requirements. In addition, patient support and/or education may be required for these drugs. The list of **specialty drugs** is subject to change. To determine which drugs are **specialty Drugs**, refer to the **drug list** by accessing the **claim administrator**'s website at www.bcbsok.com or call the customer service toll-free number on your **identification card**.

Specialty Drug (non-preferred) means a **specialty drug**, which may be a **generic** or **brand drug** that is identified on the **drug list** as a **specialty drug (non-preferred)**. The **drug list** is accessible by accessing the **claim administrator**'s website at www.bcbsok.com.

Specialty Drug (preferred) means a **specialty drug**, which may be a **generic** or **brand drug** that is identified on the **drug list** as a Preferred **specialty drug**. The **drug list** is accessible by accessing the **claim administrator**'s website at www.bcbsok.com.

Specialty Pharmacy Drugs mean specialty medications used to treat complex medical conditions, and are typically given by injection, but may be topical or taken by mouth. Such conditions such as hepatitis C, hemophilia, multiple sclerosis, and rheumatoid arthritis are treated with **specialty drugs**. To determine which drugs are **specialty drugs**, refer to the **drug list** at www.bcbsok.com or call the Customer Service number on your **identification card**.

Specialty Pharmacy Network means a limited network of **participating pharmacies** that provide the following services to **covered persons**:

- Access to high cost medications that are used in limited populations
- Special dispensing, deliver, and patient clinical support.

Therapeutic Center means an institution which is appropriately licensed, certified, or approved by the state in which it is located, and which is:

- An ambulatory surgery facility
- A freestanding radiation therapy center
- A freestanding birthing center

Value-Based Program means an outcomes-based payment arrangement and/or a coordinated care model facilitated with one or more local **providers** that is evaluated against cost and quality metrics/factors and is reflected in **provider** payment.

Well-baby nursery care means routine nursery care visits to examine a newborn member, limited to the first 48 hours following a vaginal delivery or 96 hours following delivery by cesarean section. No additional inpatient hospital visits are covered for newborn **well-baby nursery care**.

NO SURPRISES ACT AMENDMENT

Amendment Effective Date: This Amendment is effective on the **employer's** contract **anniversary date** or for the **plan year** of your **employer's** g**roup health plan** occurring on or after January 1, 2022.

The terms of this Amendment supersede the terms of the benefit booklet to which this Amendment is attached and becomes a part of the booklet. Unless otherwise required by Federal or Oklahoma law, in the event of a conflict between the terms on this Amendment and the terms of the benefit booklet, the terms on this Amendment apply. However, definitions set forth in this Amendment are for purposes of this Amendment only. Additionally, for purposes of this Amendment, references to you and your mean any **covered person,** including subscriber and **dependents**.

The booklet is hereby amended as indicated below:

I. Continuity of Care

If you are under the care of a **participating provider** as defined in the booklet who stops participating in the **plan's** network (for reasons other than failure to meet applicable quality standards, including medical incompetence or professional behavior, or fraud), you may be able to continue coverage for that **provider's covered services** at the **participating provider benefit** level if one of the following conditions is met:

1. You are undergoing a course of treatment for a serious and complex condition,
2. You are undergoing institutional or **inpatient** care,
3. You are scheduled to undergo nonelective surgery from the **provider** (including receipt of postoperative care from such **provider** with respect to such surgery),
4. You are pregnant or undergoing a course of treatment for your pregnancy, or
5. You are determined to be terminally ill.

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

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

II. Federal No Surprises Act

1. Definitions

The definitions below apply only to Section IV. Federal No Surprises Act, of this Amendment. To the extent the same terms are defined in both the booklet and this Amendment, those terms will apply only to their use in the booklet or this Amendment, respectively.

Air ambulance services means, for purposes of this Amendment only, medical transport by helicopter or airplane for patients.

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

"Emergency services" means, for purposes of this Amendment only,

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

"Non-participating **provider**" means, for purposes of this Amendment only, with respect to a covered item or service, a **physician** or other health care provider who does not have a contractual relationship with Blue Cross and Blue Shield of Oklahoma (BCBSOK) for furnishing such item or service under the **plan** to which this Amendment is attached.

"Non-participating emergency facility" means, for purposes of this Amendment only, with respect to a covered item or service, an emergency department of a **hospital** or an independent freestanding emergency department that does not have a contractual relationship with BCBSOK for furnishing such item or service under the **plan** to which this Amendment is attached.

"Participating **provider**" means, for purposes of this Amendment only, with respect to a **covered service**, a **physician** or other health care **provider** who has a contractual relationship with BCBSOK setting a rate (above which the **provider** cannot bill the **covered person**) for furnishing such item or service under the **plan** to which this Amendment is attached regardless whether the **provider** is considered a preferred or **in-network provider** for purposes of in-network or out-of-network Benefits under the subject Plan.

"Participating Facility" means, for purposes of this Amendment only, with respect to Covered Service, a **hospital** or **ambulatory surgical center** that has a contractual relationship with BCBSOK setting a rate (above which the **provider** cannot bill the **covered person**) for furnishing such item or service under the **plan** to which this Amendment is attached. Whether the **provider** is considered a **preferred** or **in-network provider** for purposes of in-network or out-of-network **benefits** under the subject **plan.**

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

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

2. <u>Federal No Surprises Act Surprise Billing Protections</u>

a. The federal No Surprises Act contains various protections relating to surprise medical bills on services performed by non-participating **providers** and non-participating emergency facilities. The items and services included in these protections ("Included Services") are listed below.

- Emergency services obtained from a non-participating **provider** or non-participating emergency facility.
- Covered non-emergency services performed by a non-participating **provider** at a participating facility (unless you give written consent and give up balance billing protections).
- Air ambulance services received from a non-participating **provider**, if the services would be covered if received from a participating **provider**.

b. <u>Claim Payments</u>

For included services, the **plan** will send an initial payment or notice of denial of payment directly to the **provider**.

c. <u>Cost-Sharing</u>

For non-Emergency Services performed by non-participating **providers** at a participating facility, and for emergency services provided by a non-participating **provider** or non-participating

emergency facility, the recognized amount is used to calculate your cost-share requirements, including **deductibles**, **copayments**, and **coinsurance**.

For air ambulance services received from a non-participating **provider**, if the services would be covered if received from a participating provider, the amount used to calculate your cost-share requirements, including **deductibles**, **copayments**, and **coinsurance**, will be the lesser of the qualifying payment amount or **billed charges**.

For included Services, these cost-share requirements will be counted toward your participating **provider** deductible and/or **out-of-pocket limit,** if any.

3. Prohibition of Balance Billing

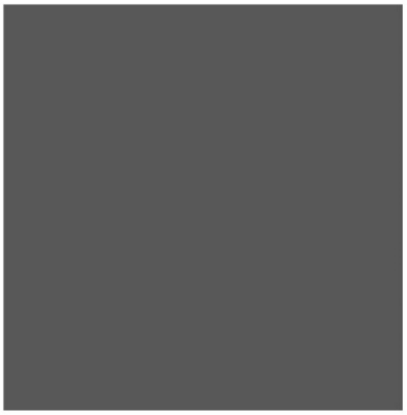
You are protected from balance billing on included services as set forth below.

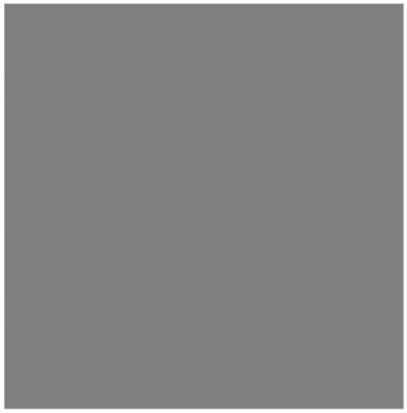
If you receive emergency services from a non-participating **provider** or non-participating emergency facility, the most the non-participating **provider** or non-participating emergency facility may bill you is your in-network cost-share. You cannot be balance billed for these emergency services unless you give written consent and give up your protections not to be balanced billed for services you receive after you are in a stable condition.

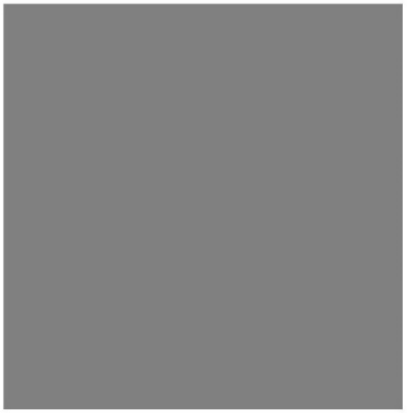
When you receive covered non-emergency services from a non-participating **provider** at a participating facility, the most those non-participating **providers** may bill you is your **plan's** in-network cost-share requirements. When you receive emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services at a participating facility, non-participating **providers** can't balance bill you and may not ask you to give up your protections not to be balance billed. If you get other services at participating facilities, non-participating **providers** can't balance bill you unless you give written consent and give up your protections.

If your **plan** includes air ambulance services as a **covered service**, and such services are provided by a non-participating **provider**, the most the non-participating **provider** may bill you is your in-network cost-share. You cannot be balance billed for these air ambulance services.

NOTE: The revisions to your plan made by this Amendment are based upon the No Surprises Act, a federal law enacted in 2020 and effective for plan years beginning on or after January 1, 2022. To the extent federal regulations are adopted or additional guidance is issued by federal regulatory agencies that alter the terms of this amendment, the regulations and any additional guidance will control over conflicting language in this amendment.







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