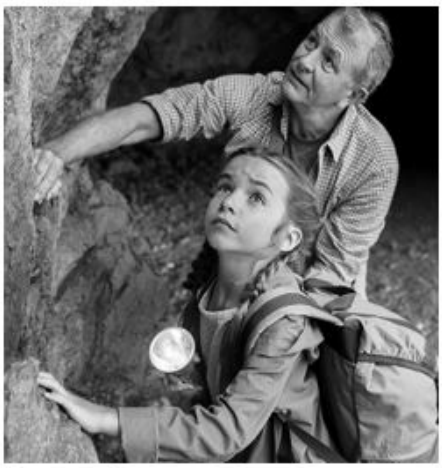
BlueCross BlueShield of Oklahoma



# 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

MOBAP0136

# Blue Advantage PPO$^{SM}$ 0136
# Blue Advantage PPO$^{SM}$ Network
# SUMMARY OF 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 your Certificate, you must receive services from Blue Advantage **providers** in Oklahoma or **BlueCard providers** outside the state of Oklahoma. These are your **in-network providers**.

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.
- Your **benefit period** is a period of one year beginning on January 1 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 of the following year. For example, 01-01-2026 to 12-31-2026.

| **Benefit Period** | Calendar Year |
|---|---|

| **Benefit Period Deductible** | **In-Network and BlueCard Providers** | **Out-of-Network Providers** |
|---|---|---|
| **Individual** | $5,100 | $10,200 |
| **Family** | $10,200 | $30,600 |
| • In- and out-of-network deductible amounts will be applied to each other<br>• The benefit period deductible is in addition to the emergency room deductible, outpatient surgery deductible, and inpatient hospital per admission deductible. | | |

| **Benefit Period Out-of-Pocket Maximum** | **In-Network and BlueCard Providers** | **Out-of-Network Providers** |
|---|---|---|
| **Individual** | $6,250 | $18,750 |
| **Family** | $12,500 | $37,500 |
| • In- and out-of-network out-of-pocket maximum amounts will be applied to each other. | | |

Please review the **COVERED SERVICES** section of your benefit booklet for additional information about the **covered services** listed below.

All limits are combined for **in-network** and **out-of-network benefits** unless stated otherwise.

## Allergy Testing and Allergy Injections

| Description | In-Network<br>You Pay | Out-of-Network<br>You Pay |
|---|---|---|
| **Allergy Testing and Allergy Injections** | 20% coinsurance after deductible | 40% coinsurance after deductible |

## Ambulance Services

| Description | In-Network<br>You Pay | Out-of-Network<br>You Pay |
|---|---|---|
| **Air Ambulance** | No coinsurance | No coinsurance |
| **Ground Ambulance** | No coinsurance | No coinsurance |

## Autism Spectrum Disorder

| Description | In-Network<br>You Pay | Out-of-Network<br>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 |
| • 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 | In-Network<br>You Pay | Out-of-Network<br>You Pay |
|---|---|---|
| **Inpatient Facility Services** | $750 per-admission deductible plus 20% coinsurance after deductible | $750 per-admission deductible plus 40% coinsurance after deductible |
| **Inpatient Physician Services** | 20% coinsurance after deductible | 40% coinsurance after deductible |
| **Outpatient Facility Services** | 20% coinsurance after deductible | 40% coinsurance after deductible |
| **Physician or Other Professional Provider Services**<br>in an outpatient setting | 20% coinsurance after deductible | 40% coinsurance after deductible |
| **Physician or Other Professional Provider Services**<br>in an office setting | $35 copay | 30% coinsurance after deductible |
| **Telemedicine Services** | $0 copay | 30% coinsurance after deductible |

## Chiropractic Care

| Description | In-Network<br>You Pay | Out-of-Network<br>You Pay |
|---|---|---|
| **Spinal/Muscle Manipulation**<br>(chiropractic care) | 20% coinsurance after deductible | 40% coinsurance after deductible |
| **Limits** | 25 visits combined each benefit period | |
| • Visit limit applied to a combination of physical therapy, occupational therapy, manipulative therapy and speech therapy, and includes both in-network and out-of-network | | |

## Durable Medical Equipment (DME)

| Description | In-Network<br>You Pay | Out-of-Network<br>You Pay |
|---|---|---|
| **DME** | 20% coinsurance after deductible | 40% coinsurance after deductible |
| • 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 an **in-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**. | | |

## Emergency Services

| Description | In-Network<br>You Pay | Out-of-Network<br>You Pay |
|---|---|---|
| **Emergency Care**<br>facility charges | $500 outpatient hospital emergency room per occurrence deductible amount (waived if admitted) then 20% coinsurance after deductible | $500 outpatient hospital emergency room per occurrence deductible amount (waived if admitted) then 20% coinsurance after deductible |
| **Emergency Ccare**<br>physician charges | 20% coinsurance after deductible | 20% coinsurance after deductible |

## Hearing Aids

| Description | In-Network<br>You Pay | Out-of-Network<br>You Pay |
|---|---|---|
| **Services to restore loss of or correct an impaired speech or hearing function with hearing aids** | Covered as any other sickness | Covered as any other sickness |
| **Hearing Aids** | 20% coinsurance after deductible | 40% coinsurance after deductible |
| **Limits** | One hearing aid per ear every 48 months, and up to four additional ear molds per benefit period of medical necessity | |

## Home Health Care

| Description | In-Network<br>You Pay | Out-of-Network<br>You Pay |
|---|---|---|
| **Home Health Care** | 20% coinsurance after deductible | 40% coinsurance after deductible |
| **Limits** | 30 visits maximum per benefit period | |

## Hospice Care

| Description | In-Network<br>You Pay | Out-of-Network<br>You Pay |
|---|---|---|
| **Hospice Services** | 20% coinsurance after deductible | 40% coinsurance after 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 | In-Network<br>You Pay | Out-of-Network<br>You Pay |
|---|---|---|
| **Home Infusion Therapy** | $50 Copay | 30% coinsurance after deductible |
| **In-Office or Infusion Suite Therapy** | $50 Copay | 30% coinsurance after deductible |
| **Outpatient Infusion Therapy**<br>performed in hospital setting | $500 Copay | 30% coinsurance after deductible |

## Inpatient Hospital Services

| Description | In-Network<br>You Pay | Out-of-Network<br>You Pay |
|---|---|---|
| **Inpatient Facility Services** | $750 per-occurrence deductible then 20% coinsurance after deductible | $750 per-occurrence deductible then 40% coinsurance after deductible |
| **Inpatient Physician Services** | 20% coinsurance after deductible | 40% coinsurance after deductible |
| **Penalty for failure to obtain prior authorization for inpatient services** | $500 per occurrence | |
| **Inpatient Rehabilitation** (physical, occupational, and/or speech therapy) | 20% coinsurance after deductible | 40% coinsurance after 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
- Inpatient rehabilitation limited to 30 days maximum per benefit period

## Maternity Services

| Description | In-Network<br>You Pay | Out-of-Network<br>You Pay |
|---|---|---|
| **Maternity Care** | $750 per occurrence deductible then 20% coinsurance after deductible | $750 per occurrence deductible then 40% coinsurance after deductible |
| **Maternity Related Newborn Care** | $750 per occurrence deductible then 20% coinsurance after deductible | $750 per occurrence deductible then 40% coinsurance after deductible |
| **Prior Authorization** | Inpatient prior authorization not required for the following length of stays:<br>• 48 hours following an uncomplicated vaginal delivery<br>• 96 hours following an uncomplicated delivery by caesarean section | |

- Maternity care is globally billed meaning:
  - Physician and Specialist Services office visit or consultation benefit located in this SUMMARY OF BENEFITS applies to initial prenatal visit (per pregnancy) to an in-network provider.
  - Benefit period deductible and coinsurance apply to subsequent visits and to all out-of-network provider services.
- Benefit period deductible does not apply to routine nursery care.

## Occupational Therapy Services

| Description | In-Network<br>You Pay | Out-of-Network<br>You Pay |
|---|---|---|
| **Occupational Therapy** in the office | 20% coinsurance after deductible | 40% coinsurance after deductible |
| **Occupational Therapy** in an outpatient setting | 20% coinsurance after deductible | 40% coinsurance after deductible |
| **Limits** | 25 visits combined each benefit period | |

- Benefits for autism spectrum disorder will not apply towards and are not subject to any occupational therapy services visits maximums.
- Visit limit applied to a combination of physical therapy, occupational therapy, manipulative therapy and speech therapy, and includes both in-network and out-of-network.

## Orthotic and Prosthetic

| Description | In-Network<br>You Pay | Out-of-Network<br>You Pay |
|---|---|---|
| **Orthotic Devices** | 20% coinsurance after deductible | 40% coinsurance after deductible |
| **Prosthetic Appliances** | 20% coinsurance after deductible | 40% coinsurance after deductible |
| **Orthotic Devices Limits** | 15 each benefit period | |

## Outpatient Hospital Services

| Description | In-Network<br>You Pay | Out-of-Network<br>You Pay |
|---|---|---|
| **Outpatient Facility Services** | $250 outpatient surgery deductible then 20% coinsurance after deductible | $250 outpatient surgery deductible then 40% coinsurance after deductible |
| **Outpatient Physician Services** | 20% coinsurance after deductible | 40% coinsurance after deductible |
| **Lab, X-ray, & Other Diagnostic Services** | No coinsurance | 30% coinsurance after deductible |
| **Outpatient Diagnostic Imaging Services** | 20% coinsurance after deductible | 40% coinsurance after deductible |
| **All other covered services not otherwise noted** | 20% coinsurance after deductible | 40% coinsurance after deductible |
| **Penalty for failure to obtain prior authorization for outpatient services** | $500 per occurrence | |

- Certain services will require prior authorization.
- Outpatient surgery deductible applies to surgical procedures received in a hospital outpatient department, ambulatory surgical facility, or other freestanding outpatient facility.
- Includes treatment of behavioral health services
- Outpatient diagnostic imaging services include:
  - Magnetic Resonance Imaging (MRI)
  - Computed Tomography (CT)
  - Positron Emission Tomography (PET)
  - and the professional review of the image(s)
- In addition to the outpatient surgery deductible, the remaining allowable charges are subject to the benefit period deductible and coinsurance.

## 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 | In-Network<br>You Pay | Out-of-Network<br>You Pay |
|---|---|---|
| **Physical Therapy**<br>in the office | 20% coinsurance after deductible | 40% coinsurance after deductible |
| **Physical Therapy**<br>in an outpatient setting | 20% coinsurance after deductible | 40% coinsurance after deductible |
| **Limits** | 25 visits combined each benefit period | |

- Benefits for autism spectrum disorder will not apply towards and are not subject to any physical therapy services visit maximums.
- Visit limit applied to a combination of physical therapy, occupational therapy, manipulative therapy and speech therapy, and includes both in-network and out-of-network.

## Physician and Specialist Services

| Description | In-Network<br>You Pay | Out-of-Network<br>You Pay |
|---|---|---|
| **Primary Care**<br>office visit<br>or consultation | $35 copay | 30% coinsurance after deductible |
| **Retail Health Clinic Visit** | $35 copay | 30% coinsurance after deductible |
| **Specialty (Specialist)**<br>office visit<br>or consultation | $60 copay | 30% coinsurance after deductible |
| **Telemedicine Services** | $0 copay | 30% coinsurance after deductible |
| **Telemedicine Services**<br>(Specialists) | $60 copay | 30% coinsurance after deductible |
| **Diagnostic Imaging Services**<br>performed in a physician's office | 20% coinsurance after deductible | 40% coinsurance after deductible |
| **Lab, X-ray, & Other Diagnostic Services**<br>performed in a physician's office | No coinsurance | 30% coinsurance after deductible |
| **Surgical Procedures**<br>performed in a physician's office | 20% coinsurance after deductible | 40% coinsurance after deductible |
| **All other covered services not otherwise noted** | 20% coinsurance after deductible | 40% coinsurance after 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 | In-Network<br>You Pay | Out-of-Network<br>You Pay |
|---|---|---|
| **Annual Mammography Screening** | No charge | No charge |
| **Covered Childhood Immunizations** | No charge | No charge |
| **All other covered preventive care services** | No charge | 30% coinsurance after deductible |

## Private Duty Nursing

| Description | In-Network<br>You Pay | Out-of-Network<br>You Pay |
|---|---|---|
| **Private Duty Nursing** | 20% coinsurance after deductible | 40% coinsurance after deductible |
| **Limits** | 85 visits per benefit period | |

## Skilled Nursing Facility

| Description | In-Network<br>You Pay | Out-of-Network<br>You Pay |
|---|---|---|
| **Skilled Nursing Facility** | 20% coinsurance after deductible | 40% coinsurance after deductible |
| **Limits** | 30 days per benefit period | |

## Speech Therapy

| Description | In-Network<br>You Pay | Out-of-Network<br>You Pay |
|---|---|---|
| **Speech Therapy**<br>in the office | 20% coinsurance after deductible | 40% coinsurance after deductible |
| **Speech Therapy**<br>in an outpatient setting | 20% coinsurance after deductible | 40% coinsurance after deductible |
| **Limits** | 25 visits combined each benefit period | |

- Benefits for autism spectrum disorder will not apply towards and are not subject to any occupational therapy services visit maximums.
- Visit limit applied to a combination of physical therapy, occupational therapy, manipulative therapy and speech therapy, and includes both in-network and out-of-network.

## Surgery

| Description | In-Network<br>You Pay | Out-of-Network<br>You Pay |
|---|---|---|
| **Physician & Facility Services** | See Inpatient Hospital Services<br>Or<br>Outpatient Hospital Services | |

## Transplant Services

| Description | In-Network<br>You Pay | Out-of-Network<br>You Pay |
|---|---|---|
| **Organ and Tissue Transplants** | 20% coinsurance after deductible | 40% coinsurance after deductible |

## Urgent Care

| Description | In-Network<br>You Pay | Out-of-Network<br>You Pay |
|---|---|---|
| **Urgent Care Center Visit**<br>performed in a physician's office | $50 copay | 30% coinsurance after deductible |
| **Urgent Care Center Visit**<br>performed in an outpatient facility | $50 copay | 30% coinsurance after deductible |
| **Surgical Procedures** | 20% coinsurance after deductible | 40% coinsurance after deductible |

- The copayment will also apply to laboratory and x-ray services performed at an in-network provider except for:
  - Magnetic Resonance Imaging (MRI)
  - Computed Tomography (CT)
  - Positron Emission Tomography (PET)
  - Myocardial Perfusion Studies (MPS)
  - and other similar imaging tests

## Wigs

| Description | In-Network<br>You Pay | Out-of-Network<br>You Pay |
|---|---|---|
| **Wigs** | 20% coinsurance after deductible | 40% coinsurance after deductible |
| **Limits** | Limited to 2 per benefit period | |

## Prior Authorization Penalty

| Description | In-Network<br>You Pay | Out-of-Network<br>You Pay |
|---|---|---|
| **Inpatient Admissions** | $500 per occurrence | |
| **Outpatient Services** | $500 per occurrence | |

# Blue Advantage PPO[SM] 0136
# SUMMARY OF BENEFITS
# for
# 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[SM] (BAM) for any questions or additional information regarding your benefits or prescription **drug list**.

The **drug list** also shows the coverage tier for **covered services:**

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

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

- How copayment and/or coinsurance amounts apply
- How payment is determined (i.e., what are the tiers)
- **Prior authorizations**
- Limitations and exclusions

| **Benefit Period** | Calendar Year |
|---|---|

## Deductible

| **Pharmacy Deductible** | **In-Network Providers** | **Out-of-Network Providers** |
|---|---|---|
| **Individual** | None | None |
| **Family** | None | None |
| • Your benefits for covered prescription drugs and related services are not subject to the benefit period deductible set forth in the SUMMARY OF BENEFITS. | | |

## Out-of-Pocket Maximum

| **Pharmacy Out-of-Pocket Maximum** | **In-Network Providers** | **Out-of-Network Providers** |
|---|---|---|
| **Individual** | None | None |
| **Family** | None | None |

- Covered prescription drugs and related services apply to the out-of-pocket maximum set forth in the SUMMARY OF BENEFITS.
- When this maximum has been paid, including any deductible, copayment and/or coinsurance amounts, for covered prescription drugs provided during a benefit period, the amount of the allowable charges covered by us for such member will increase to 100% during the remainder of the benefit period for covered prescription drugs.

**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 out-of-pocket maximum for in-network provider services.

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

- You are responsible for 50% of allowable charges, plus the applicable copayment or coinsurance shown below. Only the copayment or coinsurance will apply to your out-of-pocket maximum; 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.

Certain covered drugs may be available at no cost through a participating pharmacy for the following categories of medication: severe allergic reactions, hypoglycemia, opioid overdoses, and nitrates. For further information, call the number on the back of your identification card.

**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 | Preferred Participating Pharmacy You Pay | Participating Pharmacy You Pay | Out-of-Network Retail Pharmacy You Pay |
|---|---|---|---|
| **Tier 1** | No copay | $10 copay | $10 copay |
| **Tier 2** | $10 copay | $20 copay | $20 copay |
| **Tier 3** | $50 copay | $70 copay | $70 copay |
| **Tier 4** | $100 copay | $120 copay | $120 copay |

- In addition to any copayments and/or coinsurance amounts, you are also responsible for any charges which exceed the allowable charges.
- If you receive a brand name drug when a generic drug is available, you may incur additional costs. Refer to the PHARMACY BENEFITS section of your benefit booklet for details.
- Up to a 30-day supply
- One copayment per 30-day supply, no more than a 30-day supply.

## 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 30 days | No copay | Not covered |
| | 31 to 60 days | No copay | Not covered |
| | 61 to 90 days | No copay | Not covered |
| **Tier 2** | 1 to 30 days | $10 copay | Not covered |
| | 31 to 60 days | $20 copay | Not covered |
| | 61 to 90 days | $30 copay | Not covered |
| **Tier 3** | 1 to 30 days | $50 copay | Not covered |
| | 31 to 60 days | $100 copay | Not covered |
| | 61 to 90 days | $150 copay | Not covered |
| **Tier 4** | 1 to 30 days | $100 copay | Not covered |
| | 31 to 60 days | $200 copay | Not covered |
| | 61 to 90 days | $300 copay | Not covered |

- If you receive a brand name drug when a generic drug is available, you may incur additional costs. Refer to the PHARMACY BENEFITS section of your benefit booklet for details.
- Up to a 90-day supply
- One copayment per 30-day supply, no more than a 90-day supply.

## Mail-Order Pharmacy Program

| Mail-Order Pharmacy Program | Quantity Dispensed | Participating Mail-Order Pharmacy You Pay | Any Pharmacy other than the Participating Mail-Order Pharmacy You Pay |
|---|---|---|---|
| **Tier 1** | 1 to 30 days | No copay | Not covered |
| | 31 to 60 days | No copay | Not covered |
| | 61 to 90 days | No copay | Not covered |
| **Tier 2** | 1 to 30 days | $10 copay | Not covered |

| | | | |
|---|---|---|---|
| | 31 to 60 days | $20 copay | Not covered |
| | 61 to 90 days | $30 copay | Not covered |
| **Tier 3** | 1 to 30 days | $50 copay | Not covered |
| | 31 to 60 days | $100 copay | Not covered |
| | 61 to 90 days | $150 copay | Not covered |
| **Tier 4** | 1 to 30 days | $100 copay | Not covered |
| | 31 to 60 days | $200 copay | Not covered |
| | 61 to 90 days | $300 copay | Not covered |

- If you receive a brand name drug when a generic drug is available, you may incur additional costs. Refer to the PHARMACY BENEFITS section of your benefit booklet for details.
- Up to a 90-day supply
- One copayment per 30-day supply, no more than a 90-day supply.

## Specialty Pharmacy Program

| Specialty Pharmacy Program (30 Day Supply) | Quantity Dispensed | Specialty Network Pharmacy You Pay | Any Pharmacy other than a Specialty Network Pharmacy You Pay |
|---|---|---|---|
| **Tier 5** | 1 to 30 days | $250 copay | $250 copay plus 50% of allowable charges |
| **Tier 6** | 1 to 30 days | $350 copay | $350 copay 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. 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.

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# CERTIFICATE

This Certificate is issued according to the terms of your **group health plan**.

If a word or phrase is in bold font, it has a special meaning in this Certificate. It is defined in the **GLOSSARY** section, defined within the applicable section when used only the one time, where used in the text, or it is a title.

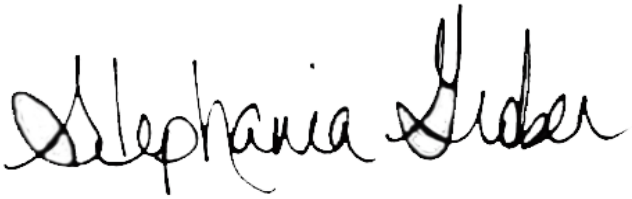
Your **group** has contracted with **Blue Cross and Blue Shield of Oklahoma** (called the **plan**, we, us, or our) to provide the **benefits** described in this Certificate. BCBSOK, having issued a **group contract** to the **group**, certifies that all persons who have:

- applied for coverage under this Certificate,
- paid for the coverage,
- satisfied the conditions specified in the **WHO GETS BENEFITS** section, and
- been approved by the **plan**,

are covered by this Certificate. Covered persons are called **subscribers** (or you, your).

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

Beginning on your **effective date**, we agree to provide you the **benefits** described in this Certificate.



President of Blue Cross and Blue Shield of Oklahoma

Your Subscriber Identification Number: _____

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

## QUICK REFERENCE

| Where to Find the Answer | |
|---|---|
| **Provider** Directory | www.bcbsok.com |
| **Prescription Drug** List | https://www.bcbsok.com/rx-drugs/drug-lists/drug-lists |
| Prior Authorization List | https://www.bcbsok.com/provider/claims/claims-eligibility/utilization-management/pa-lists |
| Preventive Services | https://www.bcbsok.com/provider/clinical/clinical-resources/preventive-care |
| • Customer Service<br>• Prior Authorization<br>• Inpatient Admissions<br>• Appeals<br>• Claim Forms<br>• **Prescription Drug**<br>• Mail-Order Services<br>• Pharmacy Locator | See **CUSTOMER SERVICE** section in this benefit booklet for contact information such as websites and mailing addresses where available |
| Definitions | See **GLOSSARY** section.<br>Defined terms are in bold in your booklet |
| Your cost share information for **covered services** | See **SUMMARY OF BENEFITS** section.<br>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<br>BCBSOK Provider Directory<br>Wellness<br>Other Online Services and Information |
| Prior authorization (for **Behavioral Health** and for Non-**Behavioral Health**) | See telephone number on the back of your identification card | |
| INPATIENT ADMISSIONS (for **Behavioral Health** and for Non-**Behavioral Health**) | See telephone number on the back of your identification card | |

| Self-Service Member Portal<br>Blue Access for Members (BAM) | Website |
|---|---|
| Provider Directory | www.bcbsok.com |
| Identification Card | www.bcbsok.com |

| For Medical Appeals<br>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<br>Appeals Division<br>PO Box 655924<br>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)<br>**Prime Therapeutics** | 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 and Blue Shield of Oklahoma<br>Claims Division<br>PO Box 655924<br>Dallas, TX 75265-5924 | Prime Therapeutics LLC<br>PO Box 25136<br>Lehigh Valley, PA 18002-5136 |

# 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.

## In-Network Benefits

Your coverage is a Preferred Provider Organization (PPO) plan. To receive **in-network benefits** as shown under your **SUMMARY OF BENEFITS (SOB)**, you must choose **participating 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 covered **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 on you 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 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 applicable to your **plan**, **employees** who have retired under the **employer's** established procedures, may continue coverage under this **contract**.

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 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.

**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.

## 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

Note: Some **employers** may only offer coverage to their **employees** and not to their **employee's dependents.**

## 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 **dependent** 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
- Cancelling all or a portion of your coverage

An address change may result in benefit changes for you and your covered **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 for newborn children vary depending on the type of coverage you are enrolled under. If you have a newborn child while covered under this Certificate, then the following rules apply:

- If you are enrolled under **subscriber** only (single) coverage, you may add coverage for a newborn effective on the child's date of birth.
  - You must submit your "Request for Change in Membership" form to the **plan** within 31 days of the child's date of birth to continue coverage.
  - If you choose not to enroll your newborn child, coverage for that child will be included under the mother's maternity benefits (provided the mother is enrolled under this Certificate) for 48 hours following a vaginal delivery, or 96 hours following a cesarean section.
- If you are enrolled under **subscriber** and spouse only coverage (if applicable), coverage for the newborn will be effective on the child's date of birth and continue for 31 days.
  - You must submit your "Request for Change in Membership" form to the **plan** within 31 days of the child's birth.
- If you are enrolled under **subscriber** and children coverage, subscriber, spouse, and children

coverage or family coverage, no application will be required to add coverage for a newborn child.

- However, you must notify the **plan** in writing of the child's birth (please submit a "Request for Change in Membership" form within 31 days).
- The effective date for the newborn will be the child's birth date.

**NOTE:** To expedite the handling of your newborn's claims, please make sure the **plan** received your "Request for Change in Membership" application (including your child's name and birth date) within 31 days of the child's birth.

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 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 after the plan receives the special enrollment request 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 premium 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.
- Your **dependent child** ceasing to be an eligible **dependent** under the plan.
- 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.
- 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.
- 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.
  - 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.

## When Coverage Ends

When a **subscriber** is no longer an eligible person or eligible **dependent**, coverage stops at the end of the billing period during which eligibility ceases, except in the following cases:

- In the case of an **employee** whose coverage is terminated under a **group health plan** that is not subject to COBRA Continuation Coverage, such **employee** and their **dependents** shall remain insured under this Certificate for a period of 63 days after such termination, unless during such period the **employee** and their **dependents** shall otherwise become entitled to similar insurance from some other source.

- When a **subscriber** ceases to be an eligible **dependent** by reason of death, coverage for that **subscriber** will cease on the date of death.

- A **subscriber**'s COBRA Continuation Coverage, when applicable, will cease on the earliest to occur of the following dates:
  - The date the billing period ends following expiration of the 18-month, 29-month or 36-month COBRA Continuation Coverage period, whichever is applicable.
  - The first day of the month that begins more than 30 days after the date of the Social Security Administration's final determination that the **subscriber** is no longer disabled (when coverage has been extended from 18 months to 29 months due to disability).
  - The date on which the **group** stops providing any **group health plan** to any **employee**.
  - The date on which coverage stops because of a **subscriber**'s failure to pay to the **group** any

premiums required for the COBRA Continuation Coverage.
- The date on which the **subscriber** first becomes (after the date of the election) covered under any other **group health plan** which does not contain any exclusion or limitation with respect to a preexisting condition applicable to the **subscriber** (or the date the **subscriber** has satisfied the preexisting condition exclusion period under that plan).
- The date on which the **subscriber** becomes (after the date of the election) entitled to benefits under Medicare.

Your coverage will terminate retroactive to your **effective date** if you or the **group** commits fraud or intentional misrepresentation of a material fact in applying for or obtaining coverage under the **group contract**. Your coverage will end immediately if you file a fraudulent claim.

If your premiums are not paid, your coverage will stop at the end of the billing period for which your premiums have been paid.

Termination of the **group contract** automatically ends all of your coverage at the same time and date. It is the responsibility of your **group** to tell you of such termination.

## What We Will Pay For After Your Coverage Ends

If your coverage terminates for any reason under a **group health plan** that is not subject to **COBRA continuation coverage, benefits** under this Certificate will end on the effective date and time of such termination. However, termination will not deprive you of any **benefits** to which you would otherwise be entitled for **covered services** incurred during the course of a **hospital** confinement that began before the date and time of termination. **Benefits** will be provided only for a period of time which is the lesser of:

- A period of time equal to the length of time you were covered under this Certificate.
- The duration of the **hospital** confinement.
- 90 days following termination of coverage.
- The date you become entitled to similar insurance through some other source.

If your coverage ends because the **member** terminates employment, or because the **group** itself is terminated, **benefits** under this Certificate will end on the effective date and time your coverage is terminated, except as provided below:

- In the event the **group health plan** is not subject to **COBRA continuation coverage**, a **subscriber** who was insured under this Certificate for six months prior to the date coverage is terminated will be entitled to an extension of **benefits** under this Certificate if:
  - **Covered services** are incurred due to illness or injury because of which the **subscriber** is Totally Disabled at the date and time such coverage is terminated.
  - The **subscriber** has not completed a plan of surgical treatment (including maternity care and delivery expenses) which began prior to the date and time of such termination of coverage.
- Coverage for the extension of **benefits** shall be limited to a period which is the lesser of:
  - The duration of the uninterrupted existence of such Total Disability or completion of a plan of surgical treatment.
  - The payment of maximum **benefits.**
  - Six months following the date and time of termination of coverage.

Your premiums must be submitted to the **plan** during the period of the extension of **benefits** and will be the same premiums which would have been charged for the coverage provided under this Certificate had termination not occurred.

The **plan** shall have no liability for any **benefits** for **covered services** incurred after the termination of this Certificate, except as provided above.

**Benefits** are not provided, even if **prior authorization** was received from the **plan**, after a **subscriber**'s coverage under this Certificate is terminated.

## When You Turn Age 65

**Plan** coverage is available to you and/or your spouse or Domestic Partner (provided your **group** covers **domestic partners**) over age 65. However, the type of coverage you receive will depend upon whether you continue to work and the rules in effect for your particular **group**, including federal regulations which apply to working people age 65 and older.

Your coverage may include:

- A continuation of **group benefits.**
- A combination of **group benefits** and Medicare.
- One of our Medicare Supplement Policies.

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

# 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 an **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 maximum**

Your coverage is designed to give you some control over the cost of your own health care. You continue to have complete freedom of choice in your **provider** selection. However, the coverage offers considerable financial advantages to you when choose to use an **in-network provider**.

This coverage operates around a group of **hospitals**, **physicians** and other **providers** who have agreed to accept no more than a reasonable, predetermined fee for their services. When you use these **in-network providers**, you will have less out-of-pocket expense.

**In contrast, when care is received from a provider who is not a network provider, *higher* deductible**, **copayment** and/or **coinsurance amounts may apply to your coverage. Refer to the SUMMARY OF BENEFITS in the front of this Certificate for additional details regarding your benefits.**

Through other network contracts with Blue Cross and Blue Shield of Oklahoma, many Oklahoma **hospitals, physicians** and other **providers** outside your network have also agreed to work together to help hold the line on health care cost increases. Although your **benefits** will be reduced when you do not use **in-network providers**, using another contracting **provider** offers some of the same advantages available to you within the **provider** network:

- The **provider** will file your claims for you (just as an **in-network provider** would do).
- Payment for **covered services** will be sent directly to the **provider**.
- These **providers** have agreed to charge **plan subscribers** no more than a "Maximum Reimbursement Allowance" for **covered services**. If your **provider** charges more than our **allowable charge** for **covered services**, you are not responsible for the difference. **However, you will be responsible for the difference, if any, between the contracting provider's allowable charge and the "Allowable Charge" which an in-network provider would have accepted for the same services.**

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 BCBSOK;
- The amount you paid your **provider** is less than the average **allowed amount** that BCBSOK 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 in some instances with 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 out-of-network **allowable amount** and the amount charged by the **out-of-network provider**. You may have to pay the out-of-network provider's charges in full and then submit a claim to us for reimbursement.

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

**The following method will be used for determining the allowable amount for providers who do not have a participating provider agreement with the plan (non-contracting providers):**

- **The allowable amount for non-contracting providers for covered services will be the lesser of:**
  - The **provider**'s billed charges.
  - The **plan**'s non-contracting **allowable amount**.

The non-contracting **allowable amount** is developed from base Medicare reimbursements, excluding any Medicare adjustments using information on the claim, and adjusted by a predetermined factor established by the **plan**. Such factor will not be less than 60% of the base Medicare reimbursement rate. However, in no event will the reimbursement exceed 90% of the lowest amount the **plan** would have paid an **in-network provider** for the same services.

For services for which a Medicare reimbursement rate is not available, the **allowable amount** for non-contracting **providers** will represent an average contract rate for **in-network providers** adjusted by a predetermined factor established by the **plan** and updated on a periodic basis. Such factor shall not be less than 100% of the average contract rate. Blue Cross and Blue Shield of Oklahoma will utilize the same claim processing rules and/or edits that it utilizes in processing **participating provider** claims for processing claims submitted by non-contracting **providers** which may also alter the **allowable amount** for a particular service. In the event the **plan** does not have any claim edits or rules, the **plan** may utilize the Medicare claim rules or edits that are used by Medicare in processing the claims. The **allowable amount** will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific claim, including, but not limited to, disproportionate share and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by the **plan** within 145 days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

In the event the non-contracting **allowable amount** does not equate to the non-contracting **provider**'s billed charges, you will be responsible for the difference, along with any applicable **deductible**, **copayment** and/or **coinsurance** amounts. This difference may be considerable. To find out an estimate of the **plan**'s non-contracting **allowable amount** for a particular service, you may call the Customer Service number shown on the back of your **identification card**.

- Notwithstanding anything in the **group health plan** to the contrary, for out-of-network **emergency care** services rendered by non-contracting **providers**, the **allowable amount** shall be equal to the greatest of the following three possible amounts—not to exceed billed charges:
  - The median amount negotiated with network or contracting **providers** for the **emergency care** services furnished
  - The amount for the **emergency care** services calculated using the same method the **plan** generally uses to determine payments for **out-of-network provider** services, but substituting the in-network or contracting cost-sharing provisions for the out-of-network or non-contracting **provider** cost-sharing provisions
  - The amount that would be paid under Medicare for the **emergency care** services.

Each of these amounts is calculated excluding any network or contracting **provider copayment** or **coinsurance** imposed with respect to the **subscriber.**

- Whenever **covered services** are received outside the state of Oklahoma from a **provider** who does not have a written agreement with Blue Cross and Blue Shield of Oklahoma or with the local Blue Cross and Blue Shield plan, the "**allowable amount**" may be determined by the Blue Cross and Blue Shield plan (Host plan) servicing the area. Please refer to *"Out-of-Area Services"* in the **GENERAL PROVISIONS** section for additional information.

**Whenever services are received from an *o*ut-of-network provider, you will be responsible for the following:**

- Charges for any services which are not covered under your **group health plan**.
- Any **deductible**, **copayment** and/or **coinsurance** amounts that are applicable to your coverage.
- The difference, if any, between your **provider**'s "billed charges" and the "allowable amount" determined by the Host 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,** has been met.

**How Family Deductibles Work**:

- Family **deductible** amounts are for all covered family members combined.
- 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** or outpatient infusion therapy **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);
  - Any other state or federally mandated benefits which stipulate a **deductible** may not be required.
- Ambulance services.
- Prescription drugs.

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 and for those services or supplies subject to a **copayment**, such as **physician** office visits, and **covered drugs** under **pharmacy benefits**, unless otherwise listed as an exception above.

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

If "**deductible credit** applies". This means if your **group** changed health insurance carriers during your **benefit period**, expenses applied to your prior carrier's **benefit period deductible** will be applied to the **benefit period deductible** of your initial **benefit period** under this Certificate.

## 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, occupational therapy, speech therapy and manipulative therapy billed separately from an office visit
- 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)
  - and other similar imaging tests
- Outpatient treatment therapies or services such as radiation therapy, chemotherapy, and renal dialysis
- Prescription drugs
- Durable medical equipment (DME)

## Out-of-Pocket Maximum

The **out-of-pocket maximum** 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**.

**How Individual Out-of-Pocket Maximums Work**

When you have met the **out-of-pocket maximum** specified in your **SUMMARY OF BENEFITS**, no additional **deductible**, **copayment** and/or **coinsurance** will be required for **covered services** you receive during the remainder of your **benefit period**.

**How Family Out-of-Pocket Maximums Work**

If you have family coverage and your family's out-of-pocket payments during the **benefit period** equals the family **out-of-pocket maximum shown** under the **SUMMARY OF BENEFITS** then for the rest of the **benefit period**, all family members will have **benefits** for **covered services** (except for those charges specifically excluded below) paid by us at 100% of the **allowable amount**.

The **out-of-pocket maximum** 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

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

- There are combined **out-of-pocket maximums** 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 **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 if received from an **in-network provider**

**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.

> You are only responsible for payment of the **non-participating provider**'s billed charges if, in advance of receiving services, you signed a written notice form that complies with applicable state and/or federal law.

The requirements of federal law that impact your costs for care from **non-participating provider**s may not apply in all cases. Oklahoma law provisions relating to balance billing prohibitions, if any, 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 unprofessional 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

**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.

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 necessary** 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 whether a procedure, treatment, facility, equipment, drug, or device 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.

# 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 **medical necessity**. 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.

## Ambulance 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 **participant**, the **participant**'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 or nutritional supplements
- 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 and substance use disorder conditions provided by:
  - A **hospital**
  - Psychiatric **hospital**
  - **Residential treatment center**
  - Other **plan**-approved **provider**
- Outpatient visits with a **physician** or **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

## 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 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 NOTE: Prescription contraceptive drugs may be covered under your **PHARMACY BENEFITS**.

**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
- Any services or supplies provided for reduction mammoplasty.

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 and Anesthesia in a Hospital or Surgery Center

**Covered services** include:

- Anesthesia and facility costs for dental care
- Oral surgery
- Services for treatment or correction of a congenital defect
- 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
  - Blood glucose monitors to the legally blind
  - Insulin pumps and appurtenances thereto
  - Insulin infusion devices
  - Lancet devices
  - Podiatric appliances for prevention of complications associated with diabetes
- Supplies:
  - Test strips for glucose monitors
  - Insulin syringes
  - Injection aids
  - Cartridges for the legally blind
  - 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
- Bone Density Test
- 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
- Mandibular reconstruction devices
- 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 an **in-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.
- 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 card. 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.

## Foot (Podiatric)

**Covered services** include:

- Examinations and treatment for conditions that affect your feet and lower legs by a **physician** or podiatrist.

The following are **not covered services**:

- Supplies in connection with foot care for flat feet, fallen arches, or chronic foot strain
- Foot care only to improve comfort or appearance such as care for
  - Subluxation
  - Corns
  - Non-surgical care for bunions
  - Calluses
  - Toenails
  - And the like

- Orthopedic shoes, custom made shoes, built up shoes or cast shoes
- Arch supports or shoe inserts to support the arch
- In the absence of diabetes: the removal of warts, corns, calluses or cutting of toenails

## Hearing Aid 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 professional provider** acting within the scope of their license.
- Any related services necessary to access, select, and adjust or fit a hearing aid
- 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** as 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.

## 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** (including but not limited to, diabetes self-management training)
- Medical and surgical supplies
- Prescribed drugs
- Oxygen and its administration

The following are **not covered services**:

- Durable medical equipment
- Food or home delivered meals

- Infusion therapy, except when you have received prior authorization from the plan for these services
- Intravenous drug, fluid, or nutritional therapy, except when you have received prior authorization from the plan for these services
- Maintenance therapy
- Homemaker services
- Services provided primarily for **custodial care**
- Speech therapy
- Transportation services

**Home health agency** means a business that provides home health care and is licensed, approved, or certified by the appropriate agency of the state in which it is located or is certified by Medicare as a supplier of home health care.

**Home health care** means the health care services which are provided during a visit by a home health agency to patients confined at home due to a sickness or injury requiring skilled health services on an intermittent, part-time basis.

## 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.

## 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.

## 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
  - Rehabilitation care
- Ancillary services such as:
  - Anesthesia supplies and services rendered by an employee of the **hospital** or **other professional provider**
  - Prescribed drugs
  - Diagnostic services
  - Lab work
  - Medical and surgical dressings, supplies, casts and splints
  - Operating, delivery and treatment rooms
  - Oxygen
  - Subdermal implanted devices or appliances necessary for the improvement of physiological function
  - Therapy service
  - Whole blood, blood processing and administration

*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 $500, provided the Plan determines that benefits are available upon receipt of a claim.**

**Rehabilitation care** means **inpatient hospital** services, including physical therapy, speech therapy, and occupational therapy, provided by the rehabilitation department of a **hospital** or other plan-approved rehabilitation facility, after the acute care stage of an illness or injury.

## Inpatient Hospital Preadmission Testing

**Covered services** include:

- Preoperative tests as an outpatient, if the tests would have been covered had you received them as an inpatient in a **hospital**

The following are **not covered services**:

- Preoperative tests if you cancel or postpone the surgery

## Maternity Care

**Covered services** include:

- Inpatient care for the birthing parent and newborn **child** in a health care facility 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

**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
- Human donor milk
- 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).

## Medical Benefit Therapeutic Alternatives

**Covered services** include:

- Certain **prescription drugs** administered by a health care professional

Certain **prescription drugs** administered by a health care professional have therapeutic equivalents or therapeutic alternatives that are used to treat the same condition. **Benefits** may be limited to only certain therapeutic equivalents or therapeutic alternatives. However, **benefits** may be provided for the therapeutic equivalents or therapeutic alternatives that are not otherwise covered under your **benefit**, if an exception is granted.

You may contact Customer Service at the toll-free telephone number on the back of your **identification card** or visit www.bcbsok.com/find-care/medical-rx for more information about covered therapeutic equivalents or therapeutic alternatives. To request an exception, you, your prescribing health care **provider**, or your authorized representative, can call the toll-free telephone number on the back of your **identification card**.

## Therapeutic equivalents or therapeutic alternatives may be covered through your prescription drug benefit, depending on your benefit plan.

## 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
  - Diagnostic and Supplemental Examinations for Breast Cancer
  - Dialysis treatment
  - Electroconvulsive therapy
  - Inherited gene mutation testing
  - Radiation therapy treatments
  - Respiratory therapy
  - Surgery
  - Urgent care

**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.

**Benefits** will be provided for **medically necessary biomarker testing** for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a disease or condition.

**Diagnostic and Supplemental Examinations for Breast Cancer**

**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

**Benefits** for Diagnostic and Supplemental Examinations for Breast Cancer will be provided at no cost share.

**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

**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**.

**Benefits** for clinical genetic testing and evidence-based cancer imaging will be provided at no cost-share when obtained from a **participating provider**.

## Private Duty Nursing

**Covered services** include:

- Services of a practicing RN, LPN, or LVN when ordered by a **physician** and when **medically necessary**.

**Benefits** for **Private Duty Nursing** services are limited to the number of visits specified in the **SUMMARY OF BENEFITS** in the front of this Certificate.

**Private Duty Nursing services are subject to the "*Prior Authorization*" requirements of this Certificate (see UTILIZATION MANAGEMENT section). If you fail to comply with these requirements, benefits for covered services will be reduced by $500, provided the plan determines that benefits are available upon receipt of a claim.**

The following are not **covered services**:

- Services provided by a nurse who is a member of your immediate family or usually lives in your home.

## Services Delivered Via Telemedicine

**Covered services** include:

- The diagnosis and treatment of certain non-emergency medical and **behavioral health** conditions or illnesses appropriately provided through telemedicine visits instead of a traditional in-person office visit for services such as:
  - Primary 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.

## Standard Fertility Preservation Services

**Covered services** include:

- **Benefits** will be provided for those who are within reproductive age, when **medically necessary** treatments may directly or indirectly cause **iatrogenic infertility. Standard fertility preservation services** are not subject to **prior authorization** requirements.

**Iatrogenic infertility** means an impairment of fertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment, affecting reproductive organs or processes.

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

## Urgent Care

**Covered services** include:

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

## Wigs

**Covered services** include:

- Wigs or other scalp prostheses which are necessary for the comfort and dignity of the **subscriber**, and which are required due to hair loss resulting from radiation therapy or chemotherapy.

**Benefits for wigs or other scalp prostheses are limited to the maximum amount specified in the SUMMARY OF BENEFITS in the front of this Certificate.**

# PREVENTIVE CARE

In addition to the **covered services** in this benefit booklet, all preventive **covered services** 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.**

To see a listing of the preventive health services available to you at no cost through an **in-network provider** visit 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.**

# 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.

- Any services or supplies not prescribed by or upon the direction of a **physician** or other **provider**.
- Any services or supplies which the **plan** determines are not **medically necessary,** except as specified**.**
- Any services or supplies received from other than a **provider.**
- Any services or supplies which are in excess of the **allowable amount**, as determined by the **plan**.
- Any services or supplies in which the **plan** determines to be **experimental/investigational** and/or unproven in nature. You may contact Customer Service at the toll-free number on the back of your **identification card** for more information about what **experimental/investigational** services or supplies may be excluded.
- 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 or supplies received before your **effective date**.
- Any services or supplies received after your 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 services or supplies to the extent payment has been made under Medicare or to the extent governmental units provide benefits or would have provided benefits if you had applied for and claimed those benefits (some state or federal laws may affect how we apply this exclusion).
- 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 supplies for which you have no legal obligation to pay in the absence of this or like coverage.

- Any services or supplies 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 or supplies for cosmetic surgery or complications resulting therefrom, including surgery to improve or restore your appearance, unless:
  - Needed to repair conditions resulting from an accidental injury.
  - For the improvement of the physiological functioning of a malformed body member resulting from a congenital defect.

  In no event shall this exclusion be applied to deny coverage on the basis that a service or treatment is a complication that arises and/or requires treatment more than one (1) year following the excluded/non-covered cosmetic surgery.

  In no event will any care and services for breast reconstruction or implantation or removal of breast prostheses be a **covered service** unless such care and services are performed solely and directly as a result of mastectomy which is **medically necessary**.
- Any inpatient 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 services or supplies for foot care only to improve comfort or appearance such as:
  - Care for flat feet
  - Subluxation
  - Corns
  - Non-surgical care for bunions
  - Calluses
  - Toenails
  - Other like foot care services
- Any services or supplies that do not meet accepted standards of medical and/or dental care.
- Any service or supplies by more than one provider on the same day(s) for the same **covered service**.
- Elective abortion, unless the life of the pregnant individual is endangered.
- 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**, either before your **effective date** or after your coverage stops.
- Services and supplies for the following except as listed as covered in the **COVERED SERVICES** section of your benefit booklet:
  - **Dietary and nutritional services**
  - **Custodial care**, such as sitters' or homemakers' services, or care in a place that serves you primarily as a residence when you do not require skilled nursing.

- Any services related to a non-covered service. Related services are:
  - Services in preparation for the non-covered service
  - Services in connection with providing the non-covered service
  - Hospitalization required to perform the non-covered services
  - Services that are usually provided following the non-covered service, such as follow-up care or therapy after surgery.
- Any services or supplies for personal hygiene and convenience items regardless of whether or not recommended by a **physician** or other **provider**. Examples include:
  - Computers
  - Air conditioners
  - Air purifiers or filters
  - Humidifiers
  - Physical fitness equipment, including exercise bicycles or treadmills
  - Modifications to your home or vehicle
- 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 (male or female)
  - 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 decreased blood flow to the legs with pneumatic compression device high pressure rapid inflation deflation cycle, or treatment of tissue damage or disease in any location with platelet rich plasma.
- Treatment of tissue damage or disease in any location with platelet-rich plasma.
- Any services or supplies for tobacco cessation programs (not including counseling or medications as specified under PREVENTIVE CARE section of this Certificate).
- Any services, supplies, or charges for medication, drugs, or hormones to stimulate growth.
- Any services or supplies provided for the following treatment modalities:
  - Acupuncture, whether for medical or anesthesia purposes, dry needling, or trigger-point acupuncture.
  - Massage therapy, including but not limited to, effleurage, petrissage and/or tapotement.
  - Transcutaneous electrical nerve stimulator (TENS)
  - Intersegmental traction
  - All types of bone traction devices and equipment
  - Vertebral axial decompression sessions
  - Surface Electromyography EMGs, which is measurement of muscle electrical activity with electrodes placed on the skin over them.
  - Spinal manipulation under anesthesia
  - Muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron.

- Balance testing through computerized dynamic posturography sensory organization test.

- Routine, screening, or periodic physical examinations which are not included as "Preventive Care", as specified on the website of preventive health services available to you located within the PREVENTIVE CARE section of this Certificate.

- Testing of:
  - Blood for measurement of levels of:
    - Lipoprotein a; small dense low-density lipoprotein
    - Lipoprotein subclass high resolution
    - Lipoprotein subclass particle numbers
    - Lipoprotein associated phospholipase A2, which are fat/protein substances in the blood
  - Urine for measurement of collagen cross links
  - Cervicovaginal fluid for amniotic fluid protein
  - Allergen specific IgG measurement

- Any services, supplies, or drugs provided to a **subscriber** incurred outside the United States if the **subscriber** traveled to the location for the purposes of receiving medical services, supplies, or drugs.

- Female contraceptive devices when not prescribed by a licensed provider, including over-the-counter contraceptive products.

- Any services or supplies 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.

- Any services or supplies for orthognathic surgery, osteotomy or any other form of oral surgery, dentistry, or dental processes to the teeth and surrounding tissue (including complications resulting therefrom), except for:
  - The treatment of accidental injury to the jaw, sound natural teeth, mouth or face.
  - The improvement of the physiological functioning of a malformed body member resulting from a congenital defect.
  - Dental extractions performed in preparation for radiation treatment for neoplasms involving the jaw/mouth.
  - Dental extractions of diseased teeth prior to a solid organ transplant.

  In no event shall this exclusion be applied to deny coverage on the basis that a service or treatment is a complication that arises and/or requires treatment more than one (1) year following the excluded/non-covered dental procedure.

- Any services or supplies provided for dental implants or associated procedure for any complications arising from such procedures.

- Any services or supplies related to inpatient treatment of any non-covered dental procedure, except that coverage shall be provided for **hospital** services, ambulatory surgical facility services, and anesthesia services associated with any **medically necessary** dental procedure when provided to a **subscriber** who is either:
  - Severely disabled.
  - Has a medical or emotional condition which requires hospitalization or general anesthesia for dental care.
  - In the judgement of the practitioner treating the covered **dependent** child, not of sufficient

emotional development to undergo a **medically necessary** dental procedure without the use of anesthesia.

- Any services or supplies for 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 on the website of preventive health services available to you located within the **PREVENTIVE CARE** section of this Certificate.
- Any services or supplies for scanning the visible front portion of the eye with computerized ophthalmic diagnostic imaging or measuring the firmness of the front of the eye with corneal hysteresis by air impulse stimulation.
- Any services or supplies for eye surgery such as radial keratotomy, when the primary purpose is to correct:
  - Myopia (nearsightedness)
  - Hyperopia (farsightedness)
  - Astigmatism (blurring).
- Any services or supplies for 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 **COVERED SERVICES**.
  - Refractive surgery is excluded.
- Any services or supplies for orthoptic training.
- Any services or supplies for hearing aids, tinnitus maskers or examinations for prescribing or fitting them, except as specified under "Hearing Aid and Audiological Services" in the **COVERED SERVICES** section of this Certificate.
- Hearing examinations not related to the prescription or fitting of hearing aids will be a covered service only when performed in connection with:
  - The diagnosis or treatment of disease or injury.
  - As specified on the website of preventive health services available to you located within the **PREVENTIVE CARE** section of this Certificate.
- Treatment 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.
- Any services or supplies for unspecified development disorders that are not related to a specified medical condition, except as described in the **COVERED SERVICES** section under "Autism Spectrum Disorder".
- Any services for or related to Applied Behavior Analysis (ABA), except for the treatment of autism spectrum disorder as described in the **COVERED SERVICES** section under "Autism Spectrum

Disorder".

- Any services or supplies for hippotherapy, equine assisted learning or other therapeutic riding programs.
- Any services or supplies for which the **provider** of service customarily makes no direct charge to a **subscriber**.
- Any services or supplies for treatment of temporomandibular joint dysfunction, including but not limited to:
  - Diagnostic procedures
  - Splints
  - Orthodontic/orthopedic appliances
  - Restorations necessary to increase vertical dimension or to restore or maintain functional or centric occlusion
  - Alteration of teeth or jaws
  - Physical therapy
  - Medication and behavioral modification related to conditions of temporomandibular joint syndrome or any other conditions involving the jaw joint, adjacent muscles or nerves, regardless of cause or diagnosis.
- Any services, supplies, or charges related to transplantation of donor organs, tissues or bone marrow, except as specified under the **COVERED SERVICES** section under "Organ and Tissue Transplant" in this Certificate.
- Any physician standby services.
- Any services or supplies for 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.
- Any services or supplies for ductal lavage of the mammary ducts.
- Any services or supplies for human donor milk.
- Any services or supplies for 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.
- Any services or supplies for thermal capsulorrhaphy as a treatment of joint instability, including but not limited to, instability of shoulders, knees, and elbows.
- For inpatient substance use treatment that is not rendered in a **hospital**, psychiatric **hospital**, **residential treatment center** or other **plan**-approved **provider**.
- Any transportation services, except as described under "Ambulance Services" in the **COVERED SERVICES** section of this Certificate.
- Any self-injectable or other self-administered drugs purchased from a physician and administered in their office.
- Select medications may be excluded from the medical benefit when a self-administered formulation of the product is available.
- Any services or supplies which are not specifically named as **covered services** subject to any other specific exclusions and limitations in this Certificate.

- 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.
- Viscosupplementation (intra-articular hyaluronic acid injection), except for individuals currently receiving maintenance therapy.
- Any services, supplies, or charges which are not specifically named as covered services subject to any other specific exclusions and limitations in this Certificate.

We 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 **MEDICAL LIMITATIONS AND 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 this Certificate, see "Right of Reimbursement" in the **GENERAL PROVISIONS** section. You must provide to us all documents needed to enforce our rights under this provision.

# 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

**Benefits** are subject to the **deductible**, **copayment** and/or **coinsurance** amounts specified in the **SUMMARY OF BENEFITS.**

## Covered Services

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

- **Prescription drugs** mean drugs that are required by federal and state law to be dispensed only by prescription.
- **Prescription drugs** dispensed for your outpatient use, when recommended by and while under the care of a **physician** or other **provider**.
- Injectable insulin and insulin products only when dispensed according to a written prescription order by a licensed **physician** or other **provider** even though a prescription 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).
- Oral chemotherapy when prescribed by a licensed **physician**.
  - Your **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** or non-**participating pharmacy** will be provided on a basis no less favorable than intravenously administered or injected cancer medications.
- Self-injectable and other self-administered **covered prescription drugs** (including chemotherapy), when dispensed by a **participating pharmacy**.
  - Self-injectable and other self-administered drugs purchased 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** 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 administered by **participating retail pharmacy providers** in the **pharmacy vaccine network**.
    - For a current listing of vaccines available through this coverage, call Customer Service at the number listed on your **identification card** or visit our website at https://www.bcbsok.com/rx-drugs/drug-lists/drug-lists.
    - NOTE: Select vaccinations administered through **participating pharmacies** in the **pharmacy vaccine network** are not subject to the **deductible**, **copayment** and/or **coinsurance** provisions of this Certificate.
- Drugs prescribed by a **physician** or other **provider** as part of **PREVENTIVE CARE** as defined in this Certificate.
- **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 prescription 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 **generic drugs** (**preferred**) and may contain some **brand name drugs**.
- Tier 2 – includes mostly **generic drugs** (**non-preferred**) and may contain some **brand name drugs**.
- Tier 3 – includes mostly **brand name drugs** (**preferred**) and may contain some **generic drugs**.
- Tier 4 – includes mostly **brand name drugs** (**non-preferred**) and may contain some **generic drugs**.
- Tier 5 – includes mostly **specialty drugs** (**preferred**) and may contain some specialty **generic drugs**.
- Tier 6 – includes mostly **specialty drugs** (**non-preferred**) and may contain some specialty **generic drugs**.

The **drug list** is subject to periodic review and change by BCBSOK. A current list is available on our website at https://www.bcbsok.com/rx-drugs/drug-lists/drug-lists. 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 Certificate, will be reviewed by the Pharmacy and Therapeutics Committee and may be added to the applicable **drug list** and be eligible for **benefits** as outlined in the **SUMMARY OF BENEFITS for PHARMACY BENEFITS.**

## 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.

## Extended Prescription Drug Supply Program

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

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

We have selected a **mail-order pharmacy program** to fill and deliver medications. This program provides delivery of **prescription drugs** directly to your home address. All items that are covered under the **mail-order pharmacy program** are subject to the same limitations and exclusions as the **retail pharmacy program**. **Items covered through a specialty pharmacy are not covered through the mail-order pharmacy program.**

NOTE: **Prescription drugs** and other items may not be mailed outside the United States.

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

Your cost will be the appropriate **deductible**, **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

## MedsYourWay™

MedsYourWay™ ("MedsYourWay") may lower your out-of-pocket costs for select **covered drugs** purchased at select retail **participating pharmacies**. MedsYourWay is a program that automatically compares available drug discount card prices and prices under your **benefit plan** for select **covered drugs** and establishes your out-of-pocket cost to the lower price available. At the time you submit or pick up your prescription, present your **identification card** to the pharmacist. This will identify you as a **participant** in MedsYourWay and allow you the lower price available for select **covered drugs**.

The amount you pay for your prescription will be applied, if applicable, to your **deductible** and **out-of-pocket maximum**. Available select **covered drugs** and drug discount card pricing through MedsYourWay may change occasionally. Certain restrictions may apply and certain **covered drugs** or drug discount cards may not be available for the MedsYourWay program. You may experience a different out-of-pocket amount for select **covered drugs** depending upon which retail **pharmacy** is utilized. For additional information regarding MedsYourWay, please contact a customer service representative at the toll-free telephone number on the back of your **identification card** or access Blue Access for Members℠ (BAM). Participation in MedsYourWay is not mandatory and you may choose not to participate in the program at any time by contacting your customer service representative at the toll-free telephone number on the back of your **identification card** or access Blue Access for Members℠ (BAM). In the event MedsYourWay fails to provide, or continue to provide, the program as stated, there will be no impact to you. In such an event, you will pay the amount shown on your **SUMMARY OF BENEFITS**.

## Payment of Benefits

**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** we 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**, **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 us.

  **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** amount for **prescription drug orders** filled at a **participating pharmacy** or **specialty network pharmacy** will accumulate toward satisfaction of your **out-of-pocket maximum** limit for "Network Provider Services".

- Any **copayment** and **coinsurance** amount 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-pocket maximum** 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 this Certificate.

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 **provider** 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**, **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 https://www.bcbsok.com/rx-drugs/drug-lists/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.**

**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.

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.

In addition to the **GLOSSARY** section of this benefit booklet, 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.

## Prescription Drug Supply/Dispensing Limits

We have the right to determine the day supply limits at our 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 drugs,** you can obtain the following supply of a single **prescription drug** or other item covered under this Certificate (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. Cost share will be based on day supply (1-30-day supply, 31-50-day supply, 1-90-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 **prescription drugs**.

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

  You are entitled to synchronize your **prescription drug** refills for one or more chronic conditions. Synchronization means the coordination of medication refills for two or more medications that you may be taking for one or more chronic conditions such that medications are refilled on the same schedule for a given period of time. When necessary to permit synchronization, the **plan** shall apply a prorated daily cost-sharing rate to any covered medication dispensed by a **participating pharmacy**. Please call Customer Service for details.

  Refills for covered eye drop **prescription drugs** are available after 70% has been used.

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

- **Multi-Category Split-Fill Program**
  If this is your first time using select medications in certain drug classes (e.g., medications for cancer, multiple sclerosis, lung disorders, etc.) or if you have not filled one of these medications within 120 days, you may only be able to receive a partial fill (14-15-day supply) of the medication for up to the first 3 months of therapy. This is to help see how the medication is working for you.

  If you receive a partial fill, your **copayments** and/or **coinsurance** after your **deductible** will be adjusted to align with the quantity of medication dispensed.

  If the medication is working for you and your **physician** or other **provider** wants you to continue on this medication, you may be eligible to receive up to a 30-day supply after completing up to 3 months of the partial supply.

  For a list of drugs that are included in this program, visit our website at www.bcbsok.com/rx-drugs/pharmacy/pharmacy-programs.

- **Clinical Dispensing Limits Applicable to Certain Drugs**
  In addition to the supply limits stated above and regardless of the quantity of a **covered prescription drug** prescribed by a **physician** or other **provider**, we have the right to establish dispensing limits on **covered prescription 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 prescription drug** may also be denied if the drug is dispensed or delivered in a manner intended to avoid our established dispensing limit.

  If you need a drug quantity that exceeds the dispensing limit, ask your doctor to submit a request for review to us on your behalf. The request will be approved or denied after the clinical information submitted by the prescribing **provider** has been evaluated by us.

- **Controlled Substances Limitation**
  If we determine that you may be receiving quantities of controlled substance medications not supported by FDA approved dosages or recognized safety or treatment guidelines, any coverage for additional drugs may be subject to a review for **medical necessity**, appropriateness and other coverage restrictions which may include but not limited to limiting coverage to services provided by a certain **provider** and/or **pharmacy** for the prescribing and dispensing of the controlled substance medication and/or limiting coverage to certain quantities.

  Additional **copayment** and/or **coinsurance** may apply.

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

## 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**, **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.**

## 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**, **copayment** and/or **coinsurance** amount indicated in the **SUMMARY OF BENEFITS for PHARMACY BENEFITS.**

## Therapeutic Equivalent Restrictions

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

## PHARMACY LIMITATIONS AND EXCLUSIONS

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

- Drugs/products which are not included on the **drug list**, unless specifically covered elsewhere in this Certificate 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 Certificate.
- Devices, technologies, and/or **durable medical equipment** of any type (even though such devices may require a **prescription order**), such as, but not limited to, therapeutic devices, artificial appliances, digital health technologies and/or applications, or similar devices (**except** disposable hypodermic needles and syringes for self-administered injections).
- Pharmaceutical aids such as excipients found in the USP-NF (United States Pharmacopeia-National Formulary) including but not limited to, preservatives, solvents, ointment bases, and flavoring, coloring, diluting, emulsifying and suspending agents.
- Administration or injection of any drugs (except for select vaccines administered by a **participating pharmacy**).
- Vitamins (**except** those vitamins which by law require a **prescription 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.

- Any services provided or items furnished for which the **pharmacy** normally does not charge.
- Infertility and fertility medications, except for medications for standard fertility preservation services related to iatrogenic infertility.
- Prescription contraceptive devices or non-prescription contraceptive materials (**except** oral contraceptive medications which are **prescription drugs**). However, coverage for prescription contraceptive devices is provided under the **COVERED SERVICES** section of this Certificate.
- Drugs required by law to be labeled: "Caution ¾ 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.
- 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 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.
- 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**.
- Athletic performance enhancement drugs.
- Compounded medications. For purposes of this exclusion, "compounded medications" are customized medications made by mixing, assembling, packaging, or labeling drugs that are not commercially available in a specific dosage form, strength or formulation.
- Replacement of drugs or other items that have been lost, stolen, destroyed or misplaced.
- Shipping, handling or delivery charges.
- Certain drug classes where there are over-the-counter alternatives available.

- Non-sedating antihistamine drugs and combination medications containing a non-sedating antihistamine and decongestant.
- **Brand name** proton pump inhibitors.
- Repackages, 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.
- 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.

# UTILIZATION 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 and not be able to bill you.

We recommend you confirm with your **provider** if **prior authorization** has been obtained. For additional information about **prior authorization** for services outside of our **service area**, please refer to the BlueCard® Program section.

> **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 "BlueCard® Program" in the **GENERAL PROVISIONS.**

**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.**

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 **recommended 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/where-you-go-matters/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.

Note: No provision found in this section guarantees payment of **benefits**. Actual availability of **benefits** is subject to eligibility and the other terms, conditions, limitations, and exclusions under your **plan.**

# CLAIM FILING AND APPEALS 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.

When you receive care and **covered services** from an **out-of-network provider**, you may be required to file your own claim. You must provide proper notice to us when you receive care for **covered services**.

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.<br>• 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 by us within 15 days, we will accept written proof covering the occurrence, character, and extent of loss for which the claim is made along with your itemized bill. |
| **Proof of Loss (claim)** | • A completed claim form and any additional information required.<br>• File each **participant's** expenses and claim form separately. **Deductibles** and **benefits** are applied to each **participant** separately. Include itemized bills from the **provider**, labs, etc., on their letterhead showing the medical services performed, who performed the services, dates of service, charges for services, diagnosis, and **participant's** full 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.<br>• 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**.<br>• 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 Claims Division 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.

| Filing a Prescription Drug Claim | Requirement | Deadline |
|---|---|---|
| **Mail-Order Program** | • A completed mail service prescription drug claim form | • Within 90 days.<br>• **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<br>• 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.<br>• 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. |

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<br>Claims Division<br>PO Box 655924<br>Dallas, TX 75265-5924 | Prime Therapeutics LLC<br>PO Box 25136<br>Lehigh Valley, PA 18002-5136 |

## Who Receives Payment

Benefit payments for **covered services** are made directly to contracting and non-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 it is 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 Determination

### 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, we must notify you within: | 24 hours |
| If you are notified that your claim is incomplete, you must provide information to complete your claim to us within: | 48 hours after receiving notice |
| *If we deny your initial claim, we must notify you of the denial:* | |
| If the initial claim is complete (taking into consideration medical needs), within: | 72 hours.<br>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), but 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:* | |
| If the initial claim is complete within: | 45 days for a paper claim and<br>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<br>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 benefit **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 procedures 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 other 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

An **adverse benefit determination** means a denial, reduction, or termination of or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which **benefits** are otherwise provided because it is determined to be experimental, investigational and/or unproven or not medically necessary or appropriate.

If an ongoing course of treatment had been approved by the plan and the plan reduces or terminates such treatment (other than by amendment or termination of this Certificate) before the end of the approved treatment period, that is also an adverse benefit determination.

**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**
- 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 terminating or reducing an authorization for a current course of treatment or continued hospitalization, 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.<br><br>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 their own 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:

Claim Review Section
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 |
| 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 give deference to 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
PO 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 procedures (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 relevant to the claim for **benefits**.
- Any internal rule, guideline, procedure, or other similar reasons relied upon in the determination, and instructions on how to get 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 how to get 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**
- **Medical 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 exhaust 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 or your authorized representative, 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

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

# 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
- Termination of coverage with us
- Continuation of **group** coverage

## Agent

Your **employer** is your agent for this **plan**. Your **employer** is not the agent of BCBSOK**.**

## 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 covered **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 covered **dependents** for any **benefits** available under the **plan**. We also reserve the right to make payments directly to you.

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**, we 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**, **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, copayment and/or coinsurance amounts which may apply.**

In some cases, **covered services** may be rendered by a **provider** who has a **Participating Provider** Agreement with the **plan**, but who is *not* an **in-network provider**. These **providers** (called Blue Traditional **providers**) have agreed to charge **plan subscribers** no more than a "Maximum Reimbursement Allowance" for **covered services**. **Subscribers** who use Blue Traditional **providers** are responsible for amounts over the "allowable charge," *up to but not exceeding* the "Maximum Reimbursement Allowance" specified in the **provider**'s **Participating Provider** Agreement.

## Benefits You Are Qualified to Receive

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

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

## Limitation of Actions

No legal action may be taken to recover **benefits** within 60 days after a **properly filed claim** has been made. No such action may be taken later than three years after expiration of the time within which a **properly filed claim** is required by this Certificate. In addition, the **subscriber** must exhaust their appeal rights, as set forth in the **CLAIM FILING AND APPEALS PROCEDURES** section of this contract, before pursuing other legal remedies.

## 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 covered **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 covered **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 which 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 https://www.bcbsok.com/find-care/providers-in-your-network/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.

## Determination of Benefits and Utilization Review

The **plan**, as claims administrator, is hereby granted discretionary authority to interpret the terms and conditions of this Certificate and to determine its **benefits**.

In determining whether services or supplies are **covered services**, the **plan** will determine whether a service or supply is **medically necessary** or if such service or supply is **experimental, investigational and/or unproven**. The **plan**'s medical policies are used as guidelines for coverage determinations in health care **benefits** unless otherwise indicated. Medical technology is constantly evolving, and these medical policies are subject to change. Copies of current medical policies may be obtained from the **plan** upon request and may be found on the **plan**'s website at www.bcbsok.com.

The **plan**'s medical staff may conduct a medical review of your claims to determine that the care and services received were **medically necessary**. In the case of inpatient claims, the **plan** must also determine that the care and services were provided in the most appropriate level of care consistent with your discharge diagnosis.

**The fact that a physician or other provider prescribes, orders, recommends or approves a service or supply does not, of itself, make it medically necessary or a covered service, even if it is not specifically listed as an *Exclusion* under this Certificate.**

To assist the **plan** in its review of your claims, the **plan** may request that:

- you arrange for medical records to be provided to the **plan**; and/or
- you submit to a professional evaluation by a **provider** selected by the **plan**, at the **plan**'s expense; and/or
- a **physician** consultant or panel of **physicians** or other **providers** appointed by the **plan** review the claim.

**Failure of the subscriber to comply with the plan's request for medical records or medical evaluation may result in benefits being partially or wholly denied.**

## Out-of-Area Services

### Overview

The **plan** has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Programs". These Inter-Plan Programs operate under rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside the geographic area Blue Cross and Blue Shield of Oklahoma serves, the claim for those services may be processed through one of these Inter-Plan Programs. The Inter-Plan Programs are described generally below.

When you receive care outside the geographic area we serve, you generally obtain care from healthcare **providers** that have a contractual agreement ("**participating providers**") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("**host blue**"). In some instances, you may obtain care from healthcare providers in the Host Blue geographic area that do not have a contractual agreement ("**non-participating providers**") with the Host Blue. Blue Cross and Blue Shield of Oklahoma explains below how we pay both kinds of **providers** below.

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

When you receive **covered services** outside Blue Cross and Blue Shield of Oklahoma's service area and the claim is processed through the BlueCard Program, the amount you pay for **covered services** is calculated based on the lower of:

- The billed charges for **covered services**; or
- The negotiated price that the Host Blue makes available to Blue Cross and Blue Shield of Oklahoma.

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

Estimated pricing and average pricing also consider adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price Blue Cross and Blue Shield of Oklahoma has used for your claim because they will not be applied after a claim has already been paid.

**Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees**
Federal or state laws or regulations may require a surcharge, tax or other fee that applies to insured **employer** accounts. If applicable, Blue Cross and Blue Shield of Oklahoma will include any such surcharge, tax or other fee as part of the claim charge passed on to you.

**Special Cases: Value-Based Programs**
If you receive **covered services** under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the **provider** incentives, risk-sharing, and/or care coordinator fees that are a part of such an arrangement, except when a Host Blue passes these fees to Blue Cross and Blue Shield of Oklahoma through average pricing or fee schedule adjustments.

**Non-Participating Providers Outside Blue Cross and Blue Shield of Oklahoma's Service Area**
**Member Liability Calculation**
When **covered services** are provided outside of Blue Cross and Blue Shield of Oklahoma's service area by **non-participating providers**, the amount(s) you pay for such services will be calculated using the methodology described in the Certificate for non-contracting providers located inside our service area or the pricing arrangements required by applicable law. In these situations, you may be responsible for the difference between the amount that the **non-participating provider** bills and the payment Blue Cross and Blue Shield of Oklahoma will make for the **covered services** as set forth in this paragraph. Payments for out-of-network emergency services, certain services provided by **out-of-network providers** at in-network facilities, and out-of-network air ambulance services will be governed by applicable federal and state law.

In certain situations, Blue Cross and Blue Shield of Oklahoma may, but is not required to, in its sole and absolute discretion, use other payment methods, such as a special negotiated payment to determine the amount Blue Cross and Blue Shield of Oklahoma will pay for services provided by such **non-participating providers**. In these situations, you may be liable for the difference between the amount that the **non-participating provider** bills and the payment Blue Cross and Blue Shield of Oklahoma will make for the **covered services** as set forth in this paragraph.

**Blue Cross Blue Shield Global® Core**

If you are outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands, (hereinafter "BlueCard service area"), you may be able to take advantage of Blue Cross Blue Shield Global Core when accessing **covered services**. Blue Cross Blue Shield Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although Blue Cross Blue Shield Global Core assists you with accessing a network of inpatient, outpatient and professional **providers**, the network is not served by a Host Blue. As such, when you receive care from **providers** outside the BlueCard service area, you will typically have to pay the **providers** and submit the claims yourself to obtain reimbursement for these services.

If you need medical assistance services (including locating a doctor or hospital) outside the BlueCard service area, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week. An assistance coordinator, working with a medical professional, can arrange a physician appointment or hospitalization, if necessary.

- **Inpatient Services**
  In most cases, if you contact the service center for assistance, hospitals will not require you to pay for covered inpatient services, except for your cost-share amounts/**deductibles**, **coinsurance**, etc. In such cases, the hospital will submit your claims to the service center to begin claims processing. However, if you paid in full at the time of service, you must submit a claim to receive reimbursement for covered **services**.

- **Outpatient Services**
  Physicians, urgent care centers and other outpatient **providers** located outside the BlueCard service area will typically require you to pay in full at the time of service. You must submit a claim to obtain reimbursement for **covered services**.

- **Submitting a Blue Cross Blue Shield Global Core Claim**
  When you pay for covered services outside the BlueCard service area, you must submit a claim to obtain reimbursement. For institutional and professional claims, you should complete a Blue Cross Blue Shield Global Core claim form and send the claim form with the provider's itemized bill(s) to the service center (the address is on the form) to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available from Blue Cross and Blue Shield of Oklahoma, the service center or online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

## Participant/Provider Relationship

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

BCBSOK:

- Does not provide services or supplies but only pay for eligible expenses incurred by you or your covered **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 covered **dependents**.

The selected health care **provider** has rules and regulations that apply to care, and treatment received by you or your covered **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**.

In some cases, **covered services** may be rendered by a **provider** who has a **participating provider** agreement with the **plan**, but who is not a **network provider**. These **providers** (called Blue Traditional Providers) have agreed to charge **plan** Subscribers no more than a maximum reimbursement allowance for **covered services**. Subscribers who use Blue Traditional Providers are responsible for amounts over the **allowable charge**, up to but not exceeding the maximum reimbursement allowance specified in the provider's participating **provider** agreement.

## Value-Based Design 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, deductibles** 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.

## The Plan's Separate Financial Arrangements with Prescription Drug Providers

The **plan** hereby informs you that it has contracts, either directly or indirectly, with participating prescription drug **providers** for the provision of, and payment for, **prescription drug** services to all persons entitled to **prescription drug benefits** under individual certificates, **group** health insurance policies and contracts to which the **plan** is a party, including this Certificate, and that pursuant to the **plan**'s contracts with participating prescription drug **providers**, under certain circumstances described therein, the **plan** may receive discounts for **prescription drugs** dispensed to you. Actual discounts used to calculate your share of the cost of **prescription drugs** will vary. Some discounts are currently based on industry-wide benchmark calculations which are determined by a third party and are subject to change.

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

To help you understand how the **plan's** separate financial arrangements with participating prescription drug providers work, please consider the following example:

- Assume you have a prescription dispensed and the undiscounted amount of the prescription drug is $100. How is the $100 bill paid?
- You will have to pay the **coinsurance** amount set out in this Certificate.
- However, for purposes of calculating your **coinsurance** amount, the full amount of the prescription drug would be reduced by the discount. In our example, if the applicable discount were 20%, the $100 prescription drug bill would be reduced by 20% to $80 for purposes of calculating your **coinsurance** amount.
- In our example, if your **coinsurance** obligation is 20%, you will have to pay 20% of $80, or $16. You should note that your 20% **coinsurance** amount is based upon the discounted amount of the prescription and not the full $100 bill.

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

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

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

## The Plan's Separate Financial Arrangements with Pharmacy Benefit Managers

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

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

## Plan/Association Relationship

Each **subscriber** hereby expressly acknowledges their understanding that the **group contract** constitutes a **contract** solely between the **group** and Blue Cross and Blue Shield of Oklahoma. Blue Cross and Blue Shield of Oklahoma is a division of Health Care Service Corporation, a Mutual Legal Reserve Company, an independent licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"). The license from the Association permits Blue Cross and Blue Shield of Oklahoma to use the Blue Cross and Blue Shield service marks in the State of Oklahoma. Blue Cross and Blue Shield of Oklahoma is not contracting as the agent of the Association. It is further understood that the **group** has not entered into the **group contract** based upon representations by any person other than Blue Cross and Blue Shield of Oklahoma. No person, entity or organization other than Blue Cross and Blue Shield of Oklahoma shall be held accountable or liable to the **group** or its **subscribers** for any of Blue Cross and Blue Shield of Oklahoma's obligations to the **group** or **subscribers** created under the **group contract**. This paragraph shall not create any additional obligations whatsoever on the part of Blue Cross and Blue Shield of Oklahoma other than those obligations created under other provisions of the **group contract**.

## Refund of Benefit Payments

Your group's **plan** and BCBSOK 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.

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

## 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 covered **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 covered **dependent** agree to reimburse us from the money received for the amount of **benefits** paid or provided by us. That means you or your covered **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 covered **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 covered **dependent** 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 covered **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

If we pay or provide **benefits** for you or your covered **dependents** under this **plan,** we are subrogated to all rights of recovery which you or your covered **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.

> In this Subrogation section, **subrogation** means the substitution of one person or entity (BCBSOK) in the place of another (you or your covered **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.

**Reimbursement**

If you or one of your covered **dependents** incur expenses for sickness or injury that occurred due to the negligence of a third-party and **benefits** are provided for **covered services** described under this Certificate, you agree:

- Blue Cross and Blue Shield has the right to reimbursement for all **benefits** Blue Cross and Blue Shield provided from any and all damages collected from the third-party for those same expenses whether by action at law, settlement, or compromise, by you or your legal representative, as a result of that sickness or injury, in the amount of the total eligible charge or **provider**'s claim charge for **covered services** for which Blue Cross and Blue Shield has provided **benefits** to you, reduced by any average discount percentage ("ADP") applicable to your claim or claims.
- Blue Cross and Blue Shield is assigned the right to recover from the third-party, or their insurer, to the extent of the **benefits** Blue Cross and Blue Shield provided for that sickness or injury.

Blue Cross and Blue Shield shall have the right to first reimbursement out of all funds you, your covered **dependents** or your legal representative, are or were able to obtain for the same expenses for which Blue Cross and Blue Shield has provided **benefits** as a result of that sickness or injury.

You are required to furnish and provide any information or assistance or provide any documents that Blue Cross and Blue Shield may reasonably require in order to exercise our rights under this provision. This provision applies whether or not the third party admits liability.

When **benefits** are available to you as primary **benefits** under Medicare, those **benefits** will be decided first and **benefits** under this **plan** may be reduced accordingly. You must complete and give consents, releases, assignments, and other documents requested by us to obtain or assure reimbursement by Medicare. If you do not cooperate or enroll in Part B of the Medicare program, you will be liable for money that Medicare would have normally paid if you had cooperated or enrolled.

## SUBSCRIBER RIGHTS AND RESPONSIBILITIES

Blue Cross and Blue Shield of Oklahoma is happy to be able to serve you and provide the quality health care benefits you need and deserve. As with any health insurance plan, you, and each of your covered dependents, have certain rights and responsibilities.

1. A right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.
2. A right to be treated with respect and recognition of their dignity and their right to privacy.
3. A right to participate with practitioners in making decisions about their health care.
4. A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
5. A right to voice complaints or appeals about the organization or the care it provides.
6. A right to make recommendations regarding the organization's member rights and responsibilities policy.
7. A responsibility to supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.
8. A responsibility to follow plans and instructions for care that they have agreed to with their practitioners.
9. A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

# COORDINATION OF BENEFITS

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

Coordination of Benefits (COB) applies to your **plan** when you or your covered **dependent**, have health care coverage with more than one health insurance company. Coordination of Benefits (COB) does not apply to the **PHARMACY BENEFITS** section.

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

## Definitions

In addition to the **GLOSSARY** of this Certificate, the following definitions apply to this provision.

**Other contract** means any arrangement, 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, employer 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.
- Coverage under any tax supported or government program, including Medicare, to the extent permitted by law.

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

**Covered Service** additionally means a service or supply furnished by a **hospital**, **physician** or **other provider** for which **benefits** are provided under at least one 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.

## Effect On Benefits

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

When we are primary, we will provide **benefits** for **covered services** without regard to your coverage under any **other contract**.

**When we are secondary, the benefits we provide 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 any **other contract** which we should have made under this provision, then we have the right to pay whoever paid under the **other contract** 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 covered **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 covered **dependents** may be eligible for continued coverage. See **COBRA Continuation Coverage** in the **WHO GETS BENEFITS** 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**.

### Extension of Benefits

If this **contract** terminates (as described in the **employer's contract**), any **participant** who is totally **disabled** on the **effective date** of the termination of the **contract** shall be allowed to receive **benefits** as described in this **benefit booklet**, subject to the **benefit** limitations and maximums, for the continued

treatment of the condition causing the total disability. **Benefits** will be available for the total disability period or for 90 days following the **contract**'s termination date, whichever is less.

If your coverage under the **plan** is replaced with coverage issued by a succeeding insurance company which provides equal or greater **benefits** than those provided by this **contract**, this extension of **benefits** for total disability is not applicable.

A succeeding insurance company means an insurer that has replaced our coverage with its coverage.

**Total disability or totally disabled** means as applied to:

- An **employee**, the complete inability of the **employee** to perform all the substantial and material duties and functions of their occupation and any other gainful occupation in which the **employee** earns substantially the same compensation earned prior to disability
- A **dependent**, confinement as a bed patient in a **hospital.**

## Information Concerning The Employee Retirement Income Security Act Of 1974 (ERISA)

If the **plan** is part of an "employee welfare benefits plan" and "welfare plan" as those terms are defined in ERISA:

- The **employer** is responsible for supplying 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 give the **employer** this **benefit booklet** as a description of **benefits** available under this **plan**. Upon written request by the **employer**, we will send any information which we have that will help the **employer** in making its annual reports.
- Claims for **benefits** must be made in writing within the required time period as described in the provisions of this **plan**. Claim filing and claim review health procedures are found in the **CLAIM FILING AND APPEALS PROCEDURES** section of this **benefit booklet**.
- We are not the "administrator" as that term is defined by ERISA or the "**plan administrator**" or "plan sponsor" with regard to the **plan.**
- This **benefit booklet** is a Certificate of Coverage and not a Summary Plan Description.
- The **employer** has delegated to us the final authority and discretion to interpret the **plan** provisions and to make eligibility and **benefit** determinations.

# GLOSSARY

**Allowable Amount**, **Allowed Amount**, or **Allowable Charge(s)** 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.

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

**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**.

**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**. 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**. This list is available by accessing the website at www.bcbsok.com.

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

**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.

**Contract Date** means the corresponding date in each year after the **contract effective date** for as long as the **contract** is in force.

**Copayment/Copay** means the set amount you pay each time you receive a certain service.

**Covered Drug(s)/Covered Prescription Drug(s)** 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**)

Note: **Covered drug(s)** under **PHARMACY BENEFITS** also means insulin, insulin analogs, insulin pens, and prescriptive and non-prescriptive oral agents for controlling blood sugar levels, including disposable syringes and needles needed for self-administration.

**Covered Service(s)** 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 mean 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

**Dietary and Nutritional Services** means the education, counseling, or training of a **participant** (including printed material) regarding:

- Diet
- Regulation or management of diet or
- The assessment or management of nutrition

**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 plan** 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**, (provided your employer covers domestic partners), 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 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.

- 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), 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.

**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 (including emerging technologies, services, procedures, and service paradigms) 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, we 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/member/prescription-drug-plan-information/drug-lists.

**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/member/prescription-drug-plan-information/drug-lists.

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

**Group health plan** means a plan of, or contributed to by, and **employer** (including a self-employed person) or **employee** organization to provide health care (directly or otherwise) to the **employees**, former **employees**, the **employer**, others associated or formerly associated with the **employer** in a business relationship, or their families.

**Health Status Related Factor** means:

- Health status
- Medical condition, including both physical and mental health
- Claims experience
- Receipt of health care
- Medical history
- Genetic information

- Evidence of insurability, including conditions arising out of acts of family violence
- Disability

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

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

**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: BCBSOK 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 us, as set forth in the current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

**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/Participating Provider(s)** means a **hospital**, **other facility provider, 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**.

**Late Enrollee** means any **employee** or **dependent** eligible for enrollment who requests enrollment in an **employer's health benefit plan:**

- After the expiration of the initial enrollment period established under the terms of the first plan for which that **participant** was eligible through the **employer**
- At the expiration of an **open enrollment period**, or
- After the expiration of a special enrollment period

**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 drugs** mean 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 health care services that the **plan** determines a **hospital**, **physician** or **other provider**, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice; and

- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- not primarily for the convenience of the patient, **physician**, or other health care **provider**, and not more costly than an alternative site, service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

**Member** means an eligible person who has enrolled for coverage.

**National Drug Code (NDC)** means a national classification system for the identification of drugs.

**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.

**Open Enrollment Period** means the 31-day period preceding the next **contract date** during which **employees** and **dependents** may enroll for coverage.

**Other Provider or Other Facility Provider** means a person or entity, other than a **hospital** or **physician**, which 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 other than a **physician** who is a professional practitioner properly licensed, certified, or authorized under applicable state law or, if no state authorization is required, by a legally constituted professional association recognized by the **plan,** to engage in the delivery of health care services and who provides such services within the scope of such license or authority. Examples include:

- Advanced practice registered nurse
- Licensed professional counselor
- Physician assistant

**Out-of-Network Benefits** means the **benefits** available under the **plan** for services and supplies that are provided by an **out-of-network provider**.

**Out-of-Network/Non-Participating Provider(s)** means a **hospital**, **other facility provider, physician**, **behavioral health provider** or **other professional provider** who has not entered into an agreement with BCBSOK (or other participating Blue Cross and/or Blue Shield Plan) as a managed care **provider**.

**Out-of-Pocket/Out-of-Pocket Maximum** means once you pay this amount in **deductibles**, **copayments** and **coinsurance** for **covered services**, we pay 100% of the **allowed amount** for **covered services** for the rest of the **benefit period**.

**Partial Hospitalization Treatment Program** means BCBSOK approved the planned program of a **hospital** or substance use disorder treatment facility for the treatment of mental health conditions or substance use disorder treatment in which patients receive treatment during the day and do not spend the night. BCBSOK requires that any mental health condition and/or substance use disorder **partial hospitalization treatment program** must be licensed in the state where it is located or accredited by a national organization that is recognized by us as set forth in its current credentialing policy, and otherwise meets all other credentialing requirements set forth in such policy.

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

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

**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 **physician**, as defined under Oklahoma law, who is properly licensed to provide medical and/or surgical care under the laws of the state where the individual practices and provides services within the scope of such license.

**Plan** means 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.

**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.

**Preferred Participating Pharmacy** means a **participating pharmacy** which has a written agreement with us to provide pharmaceutical services to **participants** under this **plan** or an entity chosen by us to administer its **pharmacy benefit plan** that has been designated as a **preferred participating pharmacy**.

**Prescription Drug(s)** 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**.

**Properly Filed Claim** means a formal statement or claim regarding a loss which provides sufficient, substantiating information to allow the **plan** to determine its liability for **covered services**.
This includes:

- A completed claim form.
- The **provider's** itemized statement of services rendered and related charges.
- Medical records, when requested by the **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.

**Qualifying Event** means any one of the following events which, but for the **COBRA continuation coverage** provisions of this Certificate, would result in the loss of a **subscriber's** coverage:

- The death of the covered **employee.**
- The termination (other than by reason of a covered Employee's gross misconduct), or reduction of hours, of the covered **employee's** employment.
- The divorce or legal separation of the covered **employee** from the **employee's** spouse.

- The covered **employee** becoming entitled to benefits under Medicare.
- A **dependent child** ceasing to be eligible as defined under this Certificate.

**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.

Accepted accrediting bodies are The Joint Commission, Commission on Accreditation of Rehabilitation Facilities (CARF), Accreditation Association for Ambulatory Healthcare (AAAHC), Council on Accreditation of Services for Families and Children Inc. (COA), or National Integrated Accreditation of Healthcare Organizations (NIAHOSM). This includes any specialized licensing that may be applicable given the services to be provided or population to be served.

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

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

**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.

**Specialist** means a **physician** or **other professional provider** who provides medical services in any generally accepted medical specialty or sub-specialty.

**Specialty Drug** or **Specialty Pharmacy Drug** means **specialty drug** that are used to treat complex medical conditions, and are typically given by injection, but may be topical or taken by mouth. They also often require careful adherence to treatment plans, may have special handling or storage requirements, and may not be stocked by retail pharmacies.

**Specialty Pharmacy Program Provider** means a **participating pharmacy** which has entered into a written agreement with us to provide **specialty drugs** to you.

**Specialty Drug (Non-Preferred)** means a **specialty drug** which appears on the applicable **drug list** as a **non-preferred specialty drug**. The **drug list** is available by accessing the website at www.bcbsok.com/member/prescription-drug-plan-information/drug-lists.

**Specialty Drug (Preferred)** means a **specialty drug** which appears on the applicable **drug list** as a **preferred specialty drug**. The **drug list** is available by accessing the website at www.bcbsok.com/member/prescription-drug-plan-information/drug-lists.

**Subscriber** means the **employee** or **member** and each of their **dependents** (if any) covered under this Certificate.

**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 (day) surgery facility
- A freestanding radiation therapy center
- A freestanding birthing center

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

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

The basic protections provided by the Association are:

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

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

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

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

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

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

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

# NOTICE

## RELIGIOUS AND MORAL EXEMPTION AND ELIGIBLE ORGANIZATION ACCOMMODATION

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

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

BlueCross BlueShield of Oklahoma

# Non-Discrimination Notice

**Health Care Coverage Is Important For Everyone**

We do not discriminate on the basis of race, color, national origin (including limited English knowledge and first language), age, disability, or sex (as understood in the applicable regulation). We provide people with disabilities with reasonable modifications and free communication aids to allow for effective communication with us. We also provide free language assistance services to people whose first language is not English.

To receive reasonable modifications, communication aids or language assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, you can file a grievance with:

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

You can file a grievance by mail, fax or email. If you need help filing a grievance, please call the toll-free phone number listed on the back of your ID card (TTY: 711).

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

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

This notice is available on our website at bcbsok.com/legal-and-privacy/non-discrimination-notice

ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 855-710-6984 (TTY: 711) or speak to your provider.

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| Español<br>Spanish | ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 855-710-6984 (TTY: 711) o hable con su proveedor. |
| العربية<br>Arabic | تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 855-710-6984 (TTY: 711) أو تحدث إلى مقدم الخدمة. |



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| 中文<br>Chinese | 注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 855-710-6984（文本电话：711）或咨询您的服务提供商。 |
| Français<br>French | ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 855-710-6984 (TTY : 711) ou parlez à votre fournisseur. |
| Deutsch<br>German | ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 855-710-6984 (TTY: 711) an oder sprechen Sie mit Ihrem Provider. |
| ગુજરાતી<br>Gujarati | ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 855-710-6984 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો. |
| हिंदी<br>Hindi | ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 855-710-6984 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें। |
| Italiano<br>Italian | ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'855-710-6984 (tty: 711) o parla con il tuo fornitore. |
| 한국어<br>Korean | 주의: 한국어 를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 855-710-6984(TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오. |
| Diné<br>Navajo | SHOOH: Diné bee yáníłti'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hóló. Bee ahił hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'į' ahoot'i'ígíí éí t'áá jiik'eh hóló. Kohjį' 855-710-6984 (TTY: 711) hodíilnih doodago nika'análwo'í bich'į' hanidziih. |
| فارسي<br>Farsi | توجه: اگر فارسي صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره 855-710-6984 (تله‌تایپ: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید. |
| Polski<br>Polish | UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 855-710-6984 (TTY: 711) lub porozmawiaj ze swoim dostawcą. |
| РУССКИЙ<br>Russian | ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 855-710-6984 (TTY: 711) или обратитесь к своему поставщику услуг. |
| Tagalog<br>Tagalog | PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 855-710-6984 (TTY: 711) o makipag-usap sa iyong provider. |
| اردو<br>Urdu | توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔855-710-6984 (711:TTY) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔ |
| Việt<br>Vietnamese | LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 855-710-6984 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn. |



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