**2026 Blue Cross and Blue Shield Service Benefit Plan - Standard and Basic Option**
**Section 7. Filing a Claim for Covered Services**
**Page 137**

**Basic Option:** The Mail Service Prescription Drug Program is available only to members with primary Medicare Part B coverage under Basic Option.

**Specialty Drug Pharmacy Program**

**Standard and Basic Options:** If your physician prescribes a specialty drug that appears on our Service Benefit Plan Specialty Drug List, your physician may order the initial prescription by calling our Specialty Drug Pharmacy Program at 888-346-3731, TTY: 711, or you may send your prescription to: BCBS FEP Specialty Drug Pharmacy Program, CVS Specialty, 9310 Southpark Center Loop, Orlando, FL 32819. You will be billed later for the copayment. The Specialty Drug Pharmacy Program will work with you to arrange a delivery time and location that are most convenient for you. To order refills, call the same phone number to arrange your delivery. You may either charge your copayment to your credit card or have it billed to you later.

Note: For the most up-to-date listing of covered specialty drugs, call the Specialty Drug Pharmacy Program at 888-346-3731, TTY: 711, or visit our website, www.fepblue.org.

**Records**
Keep a separate record of the medical expenses of each covered family member, because deductibles (under Standard Option) and benefit maximums (such as those for outpatient physical therapy or preventive dental care) apply separately to each person. Save copies of all medical bills, including those you accumulate to satisfy a deductible under Standard Option. In most instances they will serve as evidence of your claim. We will not provide duplicate or year-end statements.

**Deadline for filing your claim**
Send us your claim and appropriate documentation as soon as possible. You must submit the claim by December 31 of the following year after you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided you submitted the claim as soon as reasonably possible. If we return a claim or part of a claim for additional information (e.g., diagnosis codes, dates of service, etc.), you must resubmit it within 90 days, or before the timely filing period expires, whichever is later.

Note: Timely filing for overseas pharmacy claims is limited to one year from the prescription fill date.

Note: Once we pay benefits, there is a five-year limitation on the re-issuance of uncashed checks.

**Overseas claims**
Please refer to the claims filing information in Section 5(i).

### When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond. Our deadline for responding to your claim is stayed while we await all of the additional information needed to process your claim.

### Authorized representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, a healthcare professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent. For the purposes of this Section, we are also referring to your authorized representative when we refer to you.

### Notice requirements

The Secretary of Health and Human Services has identified counties where at least 10% of the population is literate only in certain non-English languages. The non-English languages meeting this threshold in certain counties are Spanish, Chinese, Navajo, and Tagalog. If you live in one of these counties, we will provide language assistance in the applicable non-English language. You can request a copy of your explanation of benefits (EOB) statement, related correspondence, oral language services (such as phone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the healthcare provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the procedure or treatment code and its corresponding meaning.