The Choice
for Nearly 1 in 3 Americans

Your health is everything; we’ll help you keep it in shape.
Whether you are trying to improve your health or reach the next level of wellness, Blue Cross and Blue Shield of Oklahoma (BCBSOK) is here for you. Through Blue Care Connection®, BCBSOK offers online fitness programs and personal health management tools to help you learn more about wellness and how to make healthy choices.

Partner with the Leader
BCBSOK is the state’s oldest and largest private health insurer, providing benefit plans to more than half-a-million Oklahomans. As a Blue Cross member, you have access to one of the largest Oklahoma provider networks. Our easy-to-use online Provider Finder® allows you to search online for doctors, dentists, hospitals and other health care providers – all with the click of a button.

The Oklahoma Community
BCBSOK is proud to serve Oklahomans across the state and continually works to improve the health and well-being of the communities where we live and work. We recognize the vital role that community alliances play in filling the gap to a brighter, stronger and healthier future for all Oklahomans by having strong ties to local agencies like the United Way and Oklahoma Caring Foundation.

You Have Choices
The following pages contain coverage options, tools and resources to keep you informed and help you on your journey to wellness. As you review the products, think carefully about how you and your family will use these benefits. Additional information can be found at bcbsok.com.
Plan Highlights
## Benefit Summary 2012

<table>
<thead>
<tr>
<th>Service Category</th>
<th>In Network</th>
<th>Out of Network</th>
<th>In Network</th>
<th>Out of Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General Plan Information</strong></td>
<td></td>
<td></td>
<td>1st Dollar Coverage: Plan pays 100% of the first $500 of eligible charges for each individual then:</td>
<td></td>
</tr>
<tr>
<td>Network</td>
<td>BLUECHOICE</td>
<td>BLUECHOICE</td>
<td>BLUECHOICE</td>
<td>BLUECHOICE</td>
</tr>
<tr>
<td>Calendar Year Deductible (CYD)</td>
<td>$500 Ind. / $1,500 Family</td>
<td>$500 Ind. / $1,500 Family</td>
<td>$500 Ind. / $1,000 Family</td>
<td>$500 Ind. / $1,000 Family</td>
</tr>
<tr>
<td>Calendar Year Out-of-pocket Max (includes deductible)</td>
<td>$2,800 Ind. / $8,400 Family</td>
<td>$3,300 Ind. / $9,900 Family</td>
<td>$5,500 Ind. / $11,000 Family</td>
<td>$5,500 Ind. / $11,000 Family</td>
</tr>
<tr>
<td>Co-insurance</td>
<td>Plan Pays 80% after CYD</td>
<td>Plan pays 50% after CYD</td>
<td>Plan Pays 50% after CYD</td>
<td>Plan pays 50% after CYD</td>
</tr>
<tr>
<td>Lifetime Max – Medical</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Lifetime Max – Pharmacy</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Primary Care Office Visit</td>
<td>$25 copay</td>
<td>50% after CYD</td>
<td>50% after CYD</td>
<td>50% after CYD</td>
</tr>
<tr>
<td>Specialist Office Visit</td>
<td>$40 copay</td>
<td>50% after CYD</td>
<td>50% after CYD</td>
<td>50% after CYD</td>
</tr>
<tr>
<td>Diagnostic X-ray/Lab</td>
<td>80% after CYD</td>
<td>50% after CYD</td>
<td>50% after CYD</td>
<td>50% after CYD</td>
</tr>
<tr>
<td>Inpatient Hospital*</td>
<td>80% after CYD</td>
<td>Additional $300 deductible per admit, then 50% after CYD</td>
<td>50% after CYD</td>
<td>Additional $300 deductible per admit, then 50% after CYD</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>80% after CYD</td>
<td>50% after CYD</td>
<td>50% after CYD</td>
<td>50% after CYD</td>
</tr>
<tr>
<td>Well Baby Care</td>
<td>100%</td>
<td>50% after CYD</td>
<td>100%</td>
<td>50% after CYD</td>
</tr>
<tr>
<td>Adult Immunizations</td>
<td>100%</td>
<td>50% after CYD</td>
<td>100%</td>
<td>50% after CYD</td>
</tr>
<tr>
<td>Childhood Immunizations</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Routine Health Exams</td>
<td>100%</td>
<td>50% after CYD</td>
<td>100%</td>
<td>50% after CYD</td>
</tr>
<tr>
<td>Routine Mammograms</td>
<td>100% Age 35-39 one baseline, age 40+ one per year</td>
<td>100% Age 35-39 one baseline, age 40+ one per year (max benefit $115)</td>
<td>100% Age 35-39 one baseline, age 40+ one per year</td>
<td>100% Age 35-39 one baseline, age 40+ one per year (max benefit $115)</td>
</tr>
<tr>
<td>Allergy Treatment/Testing (60 tests every 24 months)</td>
<td>80% after CYD</td>
<td>50% after CYD</td>
<td>50% after CYD</td>
<td>50% after CYD</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$100 copay; then 80% after CYD (copay waived if admitted)</td>
<td>$100 copay; then 80% after CYD (copay waived if admitted)</td>
<td>50% after CYD</td>
<td>50% after CYD</td>
</tr>
<tr>
<td>Mental Health and Substance Abuse</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient*</td>
<td>80% after CYD</td>
<td>Additional $300 deductible, then 50% after CYD</td>
<td>50% after CYD</td>
<td>Additional $300 deductible, then 50% after CYD</td>
</tr>
<tr>
<td>Outpatient</td>
<td>80% after CYD</td>
<td>50% after CYD</td>
<td>50% after CYD</td>
<td>50% after CYD</td>
</tr>
</tbody>
</table>
### Benefit Summary 2012 (cont'd)

<table>
<thead>
<tr>
<th>Pharmacy: Generic &amp; Preferred Prescription Drugs</th>
<th>BLUECHOICE PPO HIGH OPTION</th>
<th>BLUECHOICE PPO BASIC OPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>In Network</strong></td>
<td><strong>Out of Network</strong></td>
<td><strong>In Network</strong></td>
</tr>
<tr>
<td><strong>Cost of Rx: $100 or less</strong></td>
<td>Member pays lesser of $25 or actual cost</td>
<td>Member pays cost of Rx up to $75 max plus dispensing fee</td>
</tr>
<tr>
<td><strong>Cost of Rx: Greater than $100</strong></td>
<td>Member pays 25% up to $50 max</td>
<td>Member pays cost of Rx up to $75 max plus dispensing fee</td>
</tr>
<tr>
<td><strong>Out-of-pocket Maximum: Generic and Preferred Drugs</strong></td>
<td>$2,500 per individual</td>
<td>No out-of-pocket maximum</td>
</tr>
<tr>
<td><strong>Supply Limit (one month)</strong></td>
<td>Greater of 34 days or 100 units</td>
<td></td>
</tr>
<tr>
<td><strong>Supply Limit (three month)</strong></td>
<td>Greater of 102 days or 300 units</td>
<td></td>
</tr>
</tbody>
</table>

### Pharmacy: Non-Preferred Prescription Drugs

<table>
<thead>
<tr>
<th><strong>Cost of Rx: $100 or less</strong></th>
<th><strong>Out of Network</strong></th>
<th><strong>Cost of Rx: Greater than $100</strong></th>
<th><strong>Out of Network</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Member pays lesser of $50 or actual cost</td>
<td>Member pays cost of Rx up to $125 max plus dispensing fee</td>
<td>Member pays 50% up to $100 max</td>
<td>Member pays cost of Rx up to $125 max plus dispensing fee</td>
</tr>
<tr>
<td><strong>Out-of-pocket Maximum: Non-preferred Drugs</strong></td>
<td>No out-of-pocket maximum</td>
<td>No out-of-pocket maximum</td>
<td>No out-of-pocket maximum</td>
</tr>
<tr>
<td><strong>Supply Limit (one month)</strong></td>
<td>Greater of 34 days or 100 units</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Supply Limit (three month)</strong></td>
<td>Greater of 102 days or 300 units</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Other Covered Services

<table>
<thead>
<tr>
<th>Service</th>
<th>BLUECHOICE PPO HIGH OPTION</th>
<th>BLUECHOICE PPO BASIC OPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Occupational &amp; Speech Therapy</strong> (Each service limited to 60 visits per CY)</td>
<td>80% after CYD</td>
<td>50% after CYD</td>
</tr>
<tr>
<td><strong>Physical and Chiropractic Therapy</strong> (Services combined limited to 60 visits per CY)</td>
<td>80% after CYD</td>
<td>50% after CYD</td>
</tr>
<tr>
<td><strong>Hearing Screening</strong> (limited to one per CY)</td>
<td>100%</td>
<td>50% after CYD</td>
</tr>
<tr>
<td><strong>Hearing Aids</strong></td>
<td>Covered as DME up to age 18</td>
<td>Covered as DME up to age 18</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment (DME), Prosthetics and Orthotics</strong></td>
<td>80% after CYD</td>
<td>50% after CYD</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility (100 days per CY)</strong>*</td>
<td>80% after CYD</td>
<td>50% after CYD</td>
</tr>
<tr>
<td><strong>Home Health Care (100 visits per CY)</strong>*</td>
<td>80% after CYD</td>
<td>50% after CYD</td>
</tr>
<tr>
<td><strong>Hospice</strong>*</td>
<td>80% after CYD</td>
<td>50% after CYD</td>
</tr>
</tbody>
</table>

*Requires Pre-Authorization

This benefit summary is a Non-Grandfathered health plan. Benefits assume, and are subject to the use of BCBSOK’s administrative policies, procedures, and medical policies. Out of network charges are paid utilizing the Blue Choice allowable amount. Members may be balanced billed by the provider. This benefit summary does not contain a complete list of benefits available to you nor does it contain a listing of exclusions, limitations, and conditions which apply to the benefits shown. Full information can be found only in the Group Contract and Certificate of Benefits.
## Dental Plan 2012

<table>
<thead>
<tr>
<th></th>
<th>IN-NETWORK</th>
<th>OUT-OF-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>$25 per person</td>
<td>$25 per person</td>
</tr>
<tr>
<td></td>
<td>Applies to:</td>
<td>Applies to:</td>
</tr>
<tr>
<td></td>
<td>• Basic Care</td>
<td>• Preventive Care</td>
</tr>
<tr>
<td></td>
<td>• Major Care</td>
<td>• Basic Care</td>
</tr>
<tr>
<td><strong>Preventive Care</strong></td>
<td>100%, no deductible</td>
<td>100% after deductible</td>
</tr>
<tr>
<td></td>
<td>NOTE: No charge for topical fluoride application</td>
<td>NOTE: No charge for topical fluoride application</td>
</tr>
<tr>
<td></td>
<td>– up to age 16</td>
<td>– up to age 16</td>
</tr>
<tr>
<td><strong>Basic Care</strong></td>
<td>85% after deductible</td>
<td>70% after deductible</td>
</tr>
<tr>
<td></td>
<td>• Fillings</td>
<td>• Fillings</td>
</tr>
<tr>
<td></td>
<td>• Extractions</td>
<td>• Extractions</td>
</tr>
<tr>
<td></td>
<td>• Endodontics</td>
<td>• Endodontics</td>
</tr>
<tr>
<td></td>
<td>• Periodontics</td>
<td>• Periodontics</td>
</tr>
<tr>
<td><strong>Major Care</strong></td>
<td>60% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td></td>
<td>• Crowns</td>
<td>• Crowns</td>
</tr>
<tr>
<td></td>
<td>• Bridges</td>
<td>• Bridges</td>
</tr>
<tr>
<td></td>
<td>• Dentures</td>
<td>• Dentures</td>
</tr>
<tr>
<td><strong>Orthodontic Care</strong></td>
<td>50%, no deductible</td>
<td>50%, no deductible</td>
</tr>
<tr>
<td></td>
<td>12-month waiting period</td>
<td>12-month waiting period</td>
</tr>
<tr>
<td></td>
<td>Available to children up to age 19</td>
<td></td>
</tr>
<tr>
<td><strong>Maximums</strong></td>
<td>$2,000 per person</td>
<td>$2,000 per person</td>
</tr>
<tr>
<td></td>
<td>• No maximum</td>
<td>• No maximum</td>
</tr>
<tr>
<td></td>
<td>• Dental Care (Calendar Year)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Orthodontia (Dependent Children)</td>
<td></td>
</tr>
</tbody>
</table>

Dental Customer Service: 1-888-381-9727

This benefit summary does not contain a complete list of benefits available to you nor does it contain a listing of exclusions, limitations and conditions which apply to the benefits shown. Full information can be found only in the Group Contract and Certificate of Benefits.

Out of Network - Members may be balanced billed by the provider for charges over the allowable amount.
PPO Overview

The PPO plan offers a wide range of benefits and the flexibility to choose any doctor or hospital when you need care. The plan includes an annual deductible that you must satisfy before you benefits begin. Qualified medical expenses are applied toward your deductible.

A Preferred Provider Organization (PPO) is a plan that allows you the freedom to choose from any in-network or out-of-network provider each time you need medical care. As a member of a PPO, you are encouraged to use BCBSOK’s network of participating doctors and hospitals. These providers are contracted to provide services to members at a discounted rate.

- Health care received from in-network providers is paid at a higher benefit level, and you usually have no claims (paperwork) to file by yourself.

- Health care received from an out-of-network physician is typically covered at a lower percentage than services received by an in-network physician. If you choose to receive care from an out-of-network provider, your out-of-pocket costs will be higher and you may have to file a claim (paperwork) to receive reimbursement for covered expenses.

To find a contracting doctor or hospital, use the Provider Finder tool at bcbsok.com. Once you become a BCBSOK member, you can also call the toll-free customer service number on the back of your member ID card.

A PPO plan from Blue Cross and Blue Shield of Oklahoma offers value with a wide choice of PPO providers.
As a member of Blue Cross and Blue Shield of Oklahoma, you will be able to choose doctors, hospitals and other providers from the BlueChoice PPO network, the most widespread network in Oklahoma. You have the freedom to choose any physician, hospital or other healthcare provider in this network and receive the highest level of benefits. Additionally, if you travel, you will have access to BlueCard® – a national program that enables members to obtain health care services while travelling across the country and in more than 200 countries and territories worldwide.

Remember – to receive the highest level of benefits, you must receive care from providers in the BlueChoice network*. BlueChoice network providers have contracted with BCBSOK to provide health care services at negotiated rates. By choosing a BlueChoice network provider, you will pay less out-of-pocket, usually won't have to file claims and you’ll get the highest level of benefits. If you choose an out-of-network provider, you will still be covered, but your out-of-pocket costs will be higher and you may be responsible for filing your own claims.

*An allowable amount is the maximum amount Blue Cross and Blue Shield of Oklahoma will reimburse a doctor or hospital for a covered service. When you receive care in-network, you will not be responsible for charges above the allowable amount. However, if you decide to receive care out-of-network, covered services will be paid at a lower level, and you may be responsible for charges in excess of the allowable amount.

Finding a BlueChoice provider is easy. Use the Provider Finder® tool located at bcbsok.com.
An Explanation of Benefits (EOB) Statement is a notification form provided to members when a health care benefits claim is processed by Blue Cross and Blue Shield of Oklahoma (BCBSOK). The EOB displays the expenses submitted by the provider and shows how the claim was processed.

The EOB has four major sections:

- **Claim Information** includes the member and patient name, the member's group and ID numbers, and the claim number.
- **Summary** highlights the financial information – the amount billed, total benefits approved and the amount you may owe the provider.
- **Service Information** identifies the health care facility or physician, dates of service and charges.
- **Coverage Information** shows what was paid to whom, what discounts and deductions apply, and what part of the total expense was not covered.

The EOB may include additional information:

- **Information About Amounts Not Covered** will show what benefit limitations or exclusions apply.
- **Information About Out-Of-Pocket Expenses** will show an amount when a claim applies toward your deductible or counts toward your out-of-pocket expenses.
- **Information About Appeals** explains your rights regarding review of claim denials.
- **Fraud Hotline** is a toll-free number you can call if you think you are being charged for services you did not receive or if you suspect any fraudulent activity.

Your EOBs are Always Available Online!

Sign up for Blue Access® for Members (BAM) at bcbsock.com for quick, convenient and confidential access to your claim information and history. To support our commitment to eco-friendly business practices, you can choose to opt out of receiving EOBs by mail. This saves resources and offers you additional confidentiality. Just go to BAM, click on User Profile and change your User Preferences.
Sample EOB

1. Account name (member's company or organization)
2. Date claim was finalized
3. Toll-free number to call for additional information
4. Member's name and mailing address
5. BCBSOK messages
6. Member's name
7. Employer or group identification number*
8. Member number that appears on the ID card*
9. Claim number*
10. Person who received the services*
11. Summary box, including the total billed by the provider for the services, the benefits approved and paid by BCBSOK, and the remainder you may owe. (See also 14, 20 and 21).
12. Provider name (top line) and description of service (below)
13. Beginning and end service dates
14. Amount billed by the provider for each service
15. Portion of the billed amount not covered by the plan (a footnote explains the reason)
16. Amount covered by the plan*
17. Total charges included on this claim
18. Plan reductions subtracted from billed amount, such as PPO allowances
19. Deductible and copayment or coinsurance amounts
20. Payment approved before benefits are coordinated with other insurers, such as Medicare
21. Amount the member may be responsible for paying
22. Total benefit approved for provider

* Please provide this information when contacting us about a claim.
Not all EOBs are the same. The format and content of your EOB depends on your benefit plan and the services provided. Deductible and copayment amounts vary.
Take Advantage of a Quick and Easy-to-Use Online Resource to Find a Doctor

1. Go to bcbsok.com to find contracting doctors, dentists, hospitals, pharmacies and other health care providers.

2. Click on Find a Doctor

3. Search for a Provider
   - Look up a doctor, hospital or other health care provider by name.
   - Find a doctor based on a specialty, such as dermatology or internal medicine.
   - Narrow your search to include a specific location or to find providers by gender, languages spoken, hospital affiliations and more.

Note: If you do not have Internet access, please call a Customer Service Advocate at the toll-free telephone number on the back of your identification card.

bcbsok.com/okheei
Locate a Provider Outside of Oklahoma

1. From the Provider Finder home page, click on **Find U.S. Providers outside of OK** in the More Searches section in the lower left corner.

2. Read the Important Information section and click the **Continue** button.

3. Now you are on the Blue Cross and Blue Shield National Doctor & Hospital Finder website. Enter the first three letters of your identification number on your BCBSOK member ID card. Click on the **Find Providers** button.

4. Narrow your search to include a specific location or to find providers by gender, specialty, language spoken, hospital affiliations and more.

Note: If you do not have your member ID card, click on the Guest tab, choose a product and then click on the Find Providers button.
Use BlueCard PPO When You’re Away From Home

Blue Cross and Blue Shield (BCBS) is one of the most trusted and respected names in the health care benefits industry. Thanks to the BlueCard PPO Program, you can take advantage of that reputation almost anywhere in the United States.

Through the BlueCard PPO Program, BCBS Plans work together to help ensure our customers receive reliable, affordable health care. BCBS Plans throughout the country have established PPO networks of doctors, hospitals and other health care providers. These extensive provider networks are key to the BlueCard PPO Program.

How BlueCard PPO Works

1. Always carry your most current Blue Cross and Blue Shield ID card.

2. When you’re outside of your local Plan service area and need health care, refer to your ID card and call BlueCard Access at (800) 810-BLUE (2583) for information on the nearest PPO doctors and hospitals.

3. You are responsible for calling your local BCBS Plan for precertification, when necessary. Refer to the precertification phone number on your ID card, as it differs from the BlueCard Access number.

4. When you arrive at the doctor’s office or hospital, present your ID card and the doctor or hospital will verify your membership and coverage information.

5. After you receive medical attention, your claim is routed to your local Plan for processing. All doctors and hospitals are paid directly, so you won’t have any paperwork.

6. You will only need to pay for non-covered services, as well as deductible, copayment or coinsurance amounts. Your BCBS Plan will provide an Explanation of Benefits (EOB).
Highlights
The BlueCard PPO Program

Freedom to Choose
With the BlueCard PPO Program, you have the freedom to choose your provider. However, when using contracting providers, you will receive network benefits for many services. If you choose providers who are out-of-network, you will not receive the maximum benefits allowed under your health care benefit plan.

Available Care Coast to Coast
Whether you’re at home or traveling, information you need about the BlueCard PPO Program is only a phone call away. You may obtain information regarding PPO network providers and hospitals by calling the customer service telephone number on the back of your ID card, or the BlueCard Access telephone number at (800) 810-BLUE (2583) when medical services are needed outside of your local Plan service area.

Easy Access to PPO Providers
By linking PPO networks, the BlueCard PPO Program provides you with access to one of the largest health care networks in America. As a participant utilizing PPO network providers (even while traveling outside your local Plan service area), you will receive the in-network benefits available through your health plan. Although network providers (outside of Oklahoma) may approve those services that require it, it is ultimately your responsibility to obtain this pre-notification by calling the appropriate number on the back of your ID card.

Your Card is Recognized Across the United States
Your BCBS ID card gives you access to network providers throughout the United States. The suitcase logo \[\text{PPO}\] tells providers that you are part of the BlueCard PPO Program. The subscriber number on your ID card includes a three-character alpha prefix (the three letters that precede your subscriber identification number) that identifies Blue Cross and Blue Shield of Oklahoma (BCBSOK) as your home Plan.

As a PPO member, you can enjoy peace of mind in knowing that you have access to network providers when you travel. \[\text{PPO}\].

No Paperwork or Claims to File
When physicians agree to participate in their local PPO network, they accept responsibility to eliminate many of the frustrations typically associated with other health care plans. PPO providers have also agreed to file your claims. When visiting a PPO provider, all you need to do is show your ID card with the suitcase logo \[\text{PPO}\]. You will be responsible for any applicable copayment or deductible and coinsurance amounts, in addition to any services that are not covered or not approved by BCBSOK. The physician will then file your claim with the local BCBS Plan with whom he or she is a contracting PPO provider. When your provider submits your claim, it is very important that he or she include the alpha prefix that is part of your subscriber ID number. This prefix is the key to timely and accurate claims processing.

Choosing a PPO Provider
To get the most from your PPO benefits, always use a PPO provider. Simply call customer service or the BlueCard Access line at (800) 810-BLUE (2583). The customer advocates can help you verify a contracting provider or help you locate one near you. If you have a provider in mind, you can also verify with his or her office that the provider contracts with the PPO network.

Visiting a PPO Provider
When you visit a PPO provider, simply present your ID card and remind the provider that you are a PPO member. Once services are rendered, the provider will file your claim with the local Blue Cross and/or Blue Shield Plan with whom he or she contracts.
With BlueCard Worldwide you can explore the world with peace of mind.

Like your passport, always carry your Blue Cross and Blue Shield of Oklahoma (BCBSOK) identification (ID) card with you when you travel or live abroad. Through the BlueCard Worldwide program, you have access to medical assistance services and doctors and hospitals in more than 200 countries and territories around the world.

**BlueCard Worldwide**

To take advantage of the BlueCard Worldwide program, review this information:

- Before you leave home, contact BCBSOK for coverage details. Your coverage outside the United States may be different.
- Always carry your BCBSOK Plan ID card.
- In an emergency, go directly to the nearest hospital.
- The BlueCard Worldwide Service Center is available 24 hours a day, seven days a week toll-free at (800) 810-BLUE (2583) or by calling collect at (804) 673-1177.

**Call the Service Center in these situations:**

- You need to be hospitalized or you need inpatient care. After calling the Service Center, you should also call BCBSOK customer service for pre-certification or pre-authorization. You can find the telephone number on the back of your ID card.

**Payment Information**

- Participating BlueCard Worldwide hospitals. In most cases, you should not need to pay up front for inpatient care at participating hospitals except for the out-of-pocket expenses (non-covered services, deductible, copayment and coinsurance) you normally pay. The hospital should submit the claim on your behalf.
- Doctors and/or non-participating hospitals. You will need to pay up front for services. Then you can complete a BlueCard Worldwide international claim form and send it with the bill(s) to the BlueCard Worldwide Service Center at the address on the form.

*BlueCard Worldwide is there if you need medical care in a foreign country.*
BlueCard Worldwide is there when you travel far from home.

Claim Filing
- The hospital will file your claim if the BlueCard Worldwide Service Center arranged your hospitalization. You will need to pay the hospital for the out-of-pocket expenses you normally pay.

- You must file the claim for outpatient and doctor care, or inpatient care not arranged through the BlueCard Worldwide Service Center. You will need to pay the health care provider and submit an international claim form with original bills.

Claim Forms
International claim forms are available from BCBSOK, the Service Center or online at bcbs.com/bluecardworldwide.

Remember to take this information with you when you travel outside the U.S.

BlueCard Worldwide Service Center toll-free: (800) 810-2583
or collect: (804) 673-1177
**BlueExtras** offers members and covered dependents access to savings on a variety of health care and wellness products and services. Simply show your BCBSOK ID card to a program participant to receive the special offer. To learn more about these offers, log in to Blue Access® for Members (BAM) at [bcbsok.com](http://bcbsok.com).

Through the BlueExtras program, Blue Cross and Blue Shield of Oklahoma (BCBSOK) members are eligible to save money on health care products and services that help support healthy lifestyles. These savings are for health care products and services not usually covered by your health care benefit plan. There are no claims to file, no referrals or pre-authorizations, and no additional fees to participate. It’s just one more advantage of being a BCBSOK member.

**Complementary Alternative Medicine**

(866) 656-6069

Complementary Alternative Medicine (CAM) includes a variety of therapies that may help to improve your health, prevent illness and address existing symptoms and conditions. As a BCBSOK member, you’re automatically eligible to receive up to 30 percent off standard fees through the Healthways WholeHealthMD network of more than 35,000 practitioners, spas, and wellness and fitness centers. You can access the WholeHealthMD website to search for a network practitioner by logging in to BAM.

**Jenny Craig®**

(877) JENNY70 (877-536-6970)

Jenny Craig can help you achieve your weight loss goals. Through one-on-one support provided by a trained weight loss consultant, you will receive a tailored program based on the three essential components of successful weight management: Food, Body, Mind. You can meet with your consultant in-person in a local centre, or enjoy the convenience and privacy of the Jenny Craig At Home program. To access a special savings coupon, log in to BAM.

**Seattle Sutton’s Healthy Eating®**

(800) 442-DIET (800-442-3438)

Seattle Sutton’s Healthy Eating offers convenient delivery of freshly prepared, calorie-controlled meals designed to help with weight loss and management of certain health conditions. Log in to BAM for further details and to access the Seattle Sutton’s Healthy Eating website, where you can learn more about the program or find a location near you.

**GHS**

(888) I-GET-GHS (888-443-8447)

Good drivers deserve good deals. As a BCBSOK member, you receive a five percent discount on your auto insurance when you elect to auto-debit your premiums.
Save on eyeglasses (frames and lenses), as well as contact lenses, laser vision correction services, examinations and accessories through one of the nation’s leading providers of routine vision care programs. Find out more when you log in to BAM, where you also can access a list of Davis Vision participants near you. The Davis Vision network consists of major national and regional retail locations, such as EyeMasters and Visionworks, as well as independent ophthalmologists and optometrists. You and your eligible dependents can receive discounts on laser vision correction services through the TLC/TruVision network.

Save on digital hearing aids through TruHearing. Get a hearing test at no additional charge by a licensed hearing specialist when performed for the purpose of fitting a hearing aid. Enjoy a 45-day, money-back guarantee, a three-year warranty, a one-year supply of batteries with purchase and a selection of hearing aid styles at various price levels.

Members, their parents and grandparents can save 25 percent on hearing care products and services. Receive a free hearing screening, follow-up testing, a one-year supply of batteries and a two-year limited warranty.

Receive 15 percent off home safety products, child proofing products, and infant and toddler items, as well as educational toys and videos. To access the SafeTech website, go to BAM and use the password “BCOK” when ordering online to receive your discount.

The relationship between these vendors and Blue Cross and Blue Shield of Oklahoma (BCBSOK) is that of independent contractors. BlueExtras is a discount program available to BCBSOK members. Some of the services offered through BlueExtras may be covered under your health plan. Please refer to your benefit booklet or call the customer service number on the back of your ID card for specific benefit information under your health plan. Use of BlueExtras does not affect your premium, nor do costs of BlueExtras’ services or products count toward any maximums and/or plan deductibles. Discounts are only available through participating vendors. BCBSOK does not guarantee or make any claims or recommendations regarding the services or products offered under BlueExtras. You may want to consult with your physician prior to use of these services and products. BCBSOK reserves the right to discontinue or change this discount program at any time without notice.

For more information about BlueExtras, log in to BAM at bcbsok.com. Click the My Health tab, and then the BlueExtras Discount Program link.
Wellness Resources
Sometimes managing your health requires more than doctor visits, lab tests and prescriptions.

Blue Cross and Blue Shield of Oklahoma offers these Blue Care Connection resources* to help you and your covered family members reach your health and wellness goals.

- **Personal Health Manager** – online suite of wellness resources to help you manage your health and adopt healthier behaviors
- **Blue PointsSM** – reward program for engaging in healthy activities
- **24/7 Nurseline** – around the clock, toll-free access to registered nurses for health information
- **Special Beginnings®** – maternity program offering expectant mothers ongoing support and education from prenatal to postpartum care
- **Blue Care® Advisors** – registered nurses and other health care professionals who work with you and your physician to provide education, coaching and monitoring of your chronic condition treatment plan or help you make lifestyle changes
- **Case Management** – registered nurse case managers help you cope with a complex medical situation and access the services you need
- **Behavioral Health†** – licensed behavioral health staff professionals help you access services and offer support with co-existing medical conditions or disorders such as anxiety, depression, etc.
- **Fitness Program** – take advantage of a gym membership to a nationwide network of fitness centers

*These resources can help you plan and manage your health, but do not replace the care of a doctor. To get the most out of the Blue Care Connection program, discuss the health information you receive with your doctor.

†The Behavioral Health program is only available to non-HMO members whose health plan includes behavioral health benefits through BCBSOK.
Personal Health Manager
Start Your Journey to Wellness

The Personal Health Manager can help you learn more about your health and how to make healthy changes in your life. Simply go to bcbsok.com and sign in to Blue Access® for Members, the secure member website. Then, select Personal Health Manager.
1 Navigation Bar
Use these icons to quickly find family management tools, secure messages, medical tracking charts and lists. Also, access the health encyclopedia, manage your account and keep track of medical appointments. Set up a health record and grant permission to your physician or family members to view or add information. Use family management tools to manage the health records of your dependents up to age 18.

2 New Messages
Receive secure wellness messages and answers to your “Ask A” health questions.

3 Alerts/Notifications
Set and receive reminders for appointments and medication refills.

4 My Tools
Use these tools to keep track of your medications, health status and test results, such as weight, blood pressure, glucose, cholesterol and more.

5 For Your Health
Use interactive tools to work toward a healthier lifestyle and earn Blue Points℠ rewards.
- Get Fit lets you customize and record exercise programs and activities
- Eat Right helps you follow a healthy eating plan and create nutritious meals
- Live Well provides life-skill tools to help you manage stress, the workplace and relationships
- Kids & Teens helps develop healthy habits while encouraging parent-child interaction
- Articles & Recipes lets you search for health and wellness articles and find healthy recipes
- Weight Loss gets you started on a healthy program to lose weight
- Stop Smoking gives you tools to help you quit

6 Blue Points℠
Check and redeem the Blue Points you have earned. Every time you track a fitness workout, report a meal plan or take advantage of any part of the “For Your Health” section, you earn Blue Points.

Note: The Blue Points Rules are subject to change without prior notice.

7 Interactive Symptom Checker
Help identify and understand health symptoms by clicking on parts of the body. Also, check first-aid tips.

8 Health Information and Care Centers
Read about wellness topics and health conditions.

9 Know Your Risk
Take a few minutes to learn about your health status and risks by completing a confidential Health Risk Assessment. After submitting your Health Risk Assessment, you will immediately receive a detailed report of your health status, risks and recommendations for improving your health. You can discuss your results with your doctor to set goals for improving your health. Also, you are able to earn Blue Points for completing and then updating your Health Risk Assessment.

10 Ask A Question
Ask health questions and receive answers from nurses, dietitians, trainers and life coaches. For example, you can ask for information and advice about: health conditions, preventive care, fitness and exercise programs, healthy eating, losing weight, and managing stress and relationships. Look for your personal responses in “New Messages.”

11 Health Search and Health News
Use these tools to search for health and drug information, as well as the latest health news.
Blue Access® for Members
It’s easy to find what you need @ bcbsok.com

1. **My Health**
   - Make more informed health care decisions by reading about current health topics and researching specific conditions; use decision-making tools to help you better understand medical treatment options; compare hospital performance and outcome data; and obtain cost estimates for common health services.

2. **My Coverage**
   - Confirm your coverage and your dependents’ coverage; review information about your coverage; get answers to frequently asked questions; and, if your prescription drug coverage is provided by Blue Cross and Blue Shield, you can locate a pharmacy, obtain mail service forms, order refills online and obtain the cost of your prescription.

3. **Visits & Claims**
   - View medical and dental claim details, including payment amounts, a summary of your claims by date of visit, name of doctor or dentist, total charges and status. BlueEdgeSM members can also view information about their spending accounts including activity dates and balance.

4. **Doctors & Hospitals**
   - Use the Provider Finder® to locate a network doctor, hospital or other health care provider and get driving directions.

5. **News & Updates**
   - Learn about updates to your health care benefit plan and enhancements to this site.

6. **Message Center**
   - Receive notification of pending and finalized claims via secure messaging.

7. **Quick Links**
   - Carry the Card! Need to print a temporary ID card?
   - View claim status?
   - Download a form?
   - Find a doctor, hospital or dentist?
   - Stop receiving paper statements?

8. **Visit**

9. **Contact Us**
   - Submit a question to Customer Service and a Customer Service Advocate will respond by phone or mail.

10. **User Profile**
    - Update your e-mail address and choose to receive claim statements via e-mail, instead of through the mail.

11. **Help**
    - Look up definitions of health insurance terms and get answers to frequently asked questions.

bcbsok.com/okhee
Making Fitness
Easy, Fun and Affordable!

In a world where life is constantly on the move, people need solutions to fit into their ever-changing fitness schedules. Blue Cross and Blue Shield of Oklahoma (BCBSOK) just made it easier with the Fitness Program, the latest feature from Blue Care Connection®.

Available exclusively to BCBSOK members and their covered dependents (age 18 and older), the Fitness Program provides:

• **Flexible membership**, no long-term contract required. Enroll for a one-time fee of $29 and $29 per month.*

• **Easy** online enrollment; automatic monthly payment withdrawal.

• **Online** views of your fitness center visits.

• **Blue Points℠** – earn up to 400 points per week.

• **Unlimited** access to a nationwide network of participating fitness centers and select YMCA locations.

Are you ready for fitness?
Visit bcbsok.com and log in to your **Blue Access® for Members (BAM)** account. Click the **My Health** tab to find the Fitness Program button. Use this link to search for participating locations and complete your enrollment. You can also enroll by calling 888-762-BLUE (2583) toll-free, Monday through Friday, 8 a.m. – 9 p.m., in any U.S. time zone.
Rewards beyond Health and Fitness

Regular exercise is an essential part of healthier living. It gives you energy to participate in family activities, sports, dance, travel and other everyday events that make life more enjoyable.

• Feel good about your commitment to a better you.
• Accomplish your fitness goals.
• Maintain healthy weight.
• Lower your blood pressure.
• Minimize stress.
• Reduce your risk for other health-related diseases.
• Boost your stamina and strength.
• Improve sleep.
• Improve your overall health.

Log in to BAM.
Click the My Health tab to find the Fitness Program button. Or call 888-762-BLUE (2583) toll-free, Monday through Friday, 8 a.m. – 9 p.m., in any U.S. time zone.

Make new friends, take a class, try something new!
Join the Fitness Program today.

* The one-time enrollment fee and monthly membership fee for the Fitness Program are both subject to applicable taxes.
** Please review the Blue Points Program Rules listed on the Personal Health Manager for complete information on the program. Program Rules are subject to change without prior notice.
The Fitness Program is a discount program to BCBSOK members. This program is not covered under the member’s health insurance benefit plan. Please refer to your benefit booklet or call the customer service number on the back of your ID card for specific benefit information under your health plan. Use of the Fitness Program does not affect your premium, nor do costs of Fitness Program services or products count toward your calendar year or lifetime maximums and/or plan deductibles. Members are responsible for all fees, dues, taxes and other charges related to the Fitness Program. Refer to the program terms and conditions for further details.

BCBSOK does not guarantee or make any claims or recommendations regarding the services or products offered under the Fitness Program. You may want to consult with your physician prior to use of these services and products. BCBSOK reserves the right to discontinue or change this discount program at any time without notice.

Healthways, Inc. is an independent contractor which administers the Prime Network of fitness centers. The Prime Network is made up of independently-owned and managed fitness centers.

bcbsok.com/okhee
Blue Points℠ Rewards for Healthy Living

Blue Cross and Blue Shield of Oklahoma (BCBSOK) understands how hard it can be to change habits and maintain a healthy lifestyle. Yet, sometimes your good intentions aren’t good enough. That’s why BCBSOK offers Blue Points* to keep you motivated and climbing toward your wellness goals.

How Blue Points Works
You earn Blue Points every time you engage in healthy activities, such as:

• Setting up, tracking progress and meeting plan goals in the “Get Fit,” “Eat Right” and “Live Well” tools
• Completing and updating the online Health Risk Assessment every six months
• Participating in online wellness programs
• Incorporating fitness center visits as a part of your weekly routine through the Fitness Program

Redeeming Blue Points
You can redeem your Blue Points for popular health and wellness merchandise and services at the Blue Points Account and Redemption Center.

Redeeming your points is easy. Visit the Personal Health Manager, accessed from Blue Access® for Members at bcbsok.com, and select Blue Points. Then choose your available Blue Points redemption level to start shopping!

*Blue Points Program Rules are subject to change without prior notice. See the Program Rules and Frequently Asked Questions for further information. Your company may have additional reward programs in place to encourage you to take advantage of certain preventive care and wellness activities or for making healthy changes. Check your employee benefits.
Lisa uses the tools available on the Personal Health Manager to help her maintain her weight goal. She creates personalized meal plans that fit her food preferences and dietary needs and logs her daily food intake. To complement her healthy eating plan, Lisa forms an exercise plan and reports her weekly fitness activities. Earning Blue Points for these activities keeps Lisa motivated to maintain her weight, and she is looking forward to redeeming her points for new fitness equipment.

The Entire Family Can Participate!
Your eligible dependents also can earn Blue Points. Adult and teenage dependents can earn points the same as you; however, recommended activities are based on adolescent guidelines.

Children ages six to 12 will discover their very own programs. They can earn miles that take them on a journey “Around the World.” Accumulated miles allow children to move from one destination to the next – earning stamps along the way. These stamps are redeemable for kid-friendly reward items.

Start Earning Blue Points Today
Enjoy the benefits of better health AND exciting rewards! Log in to Blue Access for Members at bcbsok.com and select Personal Health Manager from the My Health – Tools tab. Then start participating in any of the online For Your Health interactive programs.

Blue Access for Members
In addition to the Personal Health Manager and Blue Points, you can log in to Blue Access for Members, at bcbsok.com, to find personalized information about your health care coverage.

bcbsok.com/okheeii
Tobacco Cessation and Weight Management Programs

**Programs to Help Change Your Lifestyle**

Most people agree – it’s not easy to lose weight or quit smoking. That’s why Blue Cross and Blue Shield of Oklahoma (BCBSOK) wants to help. Through Blue Care Connection®, BCBSOK offers two voluntary programs specifically designed to help you succeed – at no additional charge.

- **Tobacco Cessation** – If you want to quit smoking, the Tobacco Cessation program provides personal coaching, online tools, an audio library, and discounts to wellness-related products and services.

- **Weight Management** – If you want to lose weight, the Weight Management program offers guidance and support through personal motivational coaching, an action plan for your lifestyle, online tools, an audio library, and discounts to wellness-related products and services.

**After**

yo-yo dieting and trying multiple fad diets over the years, Sheila enrolled in the BCBSOK Weight Management program to reach a healthier weight and lead a more active life.

She focused on making simple changes to her daily routine: drinking more water, eating slower, controlling portions, keeping a food journal, and walking three times per week.

Sheila is now excited about her current progress toward achieving her goal.

**Barry**

enrolled in the BCBSOK Tobacco Cessation program after smoking a pack a day for 34 years. A Wellness Coach helped him set a quit date, prepare for the psychological challenges and learn new coping skills.

Within two months, Barry completely quit smoking, began exercising and eating healthier. Now he exercises or chews sugar-free gum when he feels an urge to smoke. Barry credits the program’s support and accountability for achieving his goal.
Personal Coaching
Once you are enrolled for one of these programs, you will be assigned to your own Wellness Coach who:

- Reviews your symptoms and problems
- Provides personal assistance with goal setting, resource education, tips and periodic progress checkups
- Assesses your commitment level
- Establishes a follow-up call schedule

Your Wellness Coach can also help you if you need support with behavioral disorders. Since many health issues involve some combination of physical, mental and social causes, addressing behavioral and medical issues at the same time can lead to a better overall quality of life.

Be sure to ask questions, share your feelings and build a trusting relationship with your coach – these valuable relationships will keep you motivated.

Online Self-Guided Tools and Resources
If you are not comfortable working with a Wellness Coach, you can use a variety of online motivational and educational resource tools through the Personal Health Manager*.

Participate at your own pace and earn Blue PointsSM all while helping yourself get healthy. You also can e-mail health and wellness questions to registered nurses, dietitians, trainers and life coaches for additional support.

To enroll in an online self-management program, visit bcbsok.com and sign in to Blue Access® for Members, a secure member website. Select Personal Health Manager and click Weight Loss or Quit Smoking.

Enroll Today
There are two ways to get started with the Tobacco Cessation or Weight Management personal coaching programs:

- Call Customer Service at the phone number listed on the back of your member ID card to self-enroll.
- Receive a referral upon completion of the Health Risk Assessment on the Personal Health Manager, or participation in a health fair offered by your employer.

* The Personal Health Manager may not be available to all members because some employers have chosen another medical management program. To verify if you have access to this resource, check with your group benefits administrator or call Customer Service at the number listed on the back of your member ID card.

** Blue Points Program Rules are subject to change without prior notice.
Condition Management

Condition Management Programs
Living every day with a chronic health condition can be difficult. Blue Cross and Blue Shield of Oklahoma (BCBSOK) can help you manage your medical condition, change unhealthy behaviors and stay as healthy as possible with our comprehensive Condition Management programs.

As part of the Blue Care Connection® program and offered at no additional cost, these voluntary programs are designed for people diagnosed with chronic conditions such as asthma, diabetes, heart problems and others. When you enroll, you will have access to the best knowledge, tools and self-care techniques to help you make a difference in your health.

Benefits of Participation
The Condition Management programs work together with you, your health plan and your doctor to help identify the best ways to manage your chronic health condition and stay healthy.

Enrolling in a program can help you:

• Have fewer, milder symptoms
• Communicate better with your doctor and your health plan
• Enhance your self-management skills for improving your health and quality of life
• Miss fewer days at work

Enroll Today - and Take Control
To enroll in a Condition Management program, or to find out how one of the programs can help you, please call the Customer Service number on the back of your member ID card.

You may be targeted for program participation if you have a chronic health condition or are at risk for medical complications that could be addressed through intervention and counseling.

Claims, lab and pharmacy data; preauthorization; health risk assessments; or a doctor referral are some of the factors that help determine if a Condition Management program is right for you. You may also request to be included in these programs.

Your doctor plays an important role in treating your condition. Be sure to discuss any issues or concerns you may have with your doctor.

Reaching Out to Members at Risk
Blue Care® Advisors, registered nurses or other health care professionals, may contact you if you have certain health challenges or chronic conditions. Through regularly scheduled health counseling and coaching telephone calls, the advisor can help you identify unhealthy behaviors, set goals, adopt healthier habits and learn to manage medical conditions more effectively.

Following nationally recognized practice guidelines, the Condition Management programs* specifically target:

• Asthma
• Chronic obstructive pulmonary disease (COPD)
• Congestive heart failure (CHF)
• Coronary artery disease (CAD)
• Diabetes

* The health care needs of members are evaluated on an ongoing basis to identify opportunities for additional condition management programs.
Special Beginnings®
Maternity Program

A Healthy Start for Mothers and Babies
Every pregnancy carries some risk, with one in eight babies born preterm.* Blue Cross and Blue Shield of Oklahoma offers expectant members a confidential maternity program to help safeguard the health of both mother and baby. Special Beginnings provides you the education and support you need throughout your pregnancy – at no additional cost.

In cooperation with your physician, you will understand how to avoid risks and make informed choices, giving your baby the greatest chance of being born strong and healthy.

And since the first step to having a healthy baby is getting prenatal care, be sure to enroll in the program as soon as you find out you are pregnant.

The Special Beginnings Advantage
Throughout every stage of pregnancy, you receive:

• Pregnancy risk factor identification to determine the risk level of your pregnancy and the appropriate range for ongoing communication/monitoring

• Educational material on topics such as prenatal and postpartum nutrition, healthy lifestyle choices, fetal development, newborn care, and post-pregnancy/well-child information

• Access to pregnancy resource website for useful information and tools

• Personal telephone contact with program staff from the time of enrollment until six weeks after delivery

• Assistance in managing high-risk conditions such as gestational diabetes and preeclampsia


Getting Started Is Easy
After calling the toll-free number, you will be contacted by either phone or mail to complete a confidential questionnaire. You will be asked about your medical and obstetrical history, your current pregnancy and information about your lifestyle that could affect your baby.

Once you are enrolled, you will receive a comprehensive, pregnancy and infant care educational book, The Simple Guide to Having a Baby.

The information provided during the questionnaire helps us to determine your risk level and ongoing communication/monitoring needs throughout your pregnancy.
Regardless of your risk level, you will receive scheduled follow-up calls before and after delivery to:

- Identify any risk factors that might adversely affect your pregnancy
- Determine progress in self-management techniques
- Provide education on prenatal, postpartum and newborn care
- Reinforce your physician’s treatment plan
- Help manage high-risk conditions
- Offer assistance on how to access other pregnancy-related resources

**Enroll Today**

Call (888) 421-7781, 8 a.m. – 6:30 p.m., CT, to enroll or ask questions about the program.

For questions about your health care coverage, please consult your plan booklet, see your group benefits administrator or call the Customer Service number listed on the back of your member ID card.

Special Beginnings is not a substitute for professional medical guidance. Regular visits are important for your care. With your consent, the information we receive from you is shared with your physician to better coordinate your care. Be sure to discuss any health concerns with your physician.
24/7 Nurseline – Around-the-Clock, Toll-Free Support

The 24/7 Nurseline can help you figure out if you should call your doctor, go to the ER or treat the problem yourself.

Health concerns don’t always follow a 9-to-5 schedule. Fortunately, registered nurses are on call at (800) 581-0407 to answer your health questions, wherever you may be, 24 hours a day, seven days a week.

The 24/7 Nurseline’s registered nurses can understand your health concerns and give general health tips. Get trusted guidance on possible emergency care, urgent care, family care and more.

When should you call?
The toll-free Nurseline can help you or a covered family member get answers to health problem questions, such as:

- Asthma, back pain or chronic health issues
- Dizziness or severe headaches
- High fever
- A baby’s nonstop crying
- Cuts or burns
- Sore throat

Plus, when you call, you can access an audio library of more than 1,000 health topics—from allergies to women’s health—with more than 600 topics available in Spanish.

Note: For medical emergencies, call 911 or your local emergency services first. This program is not a substitute for a doctor’s care. Talk to your doctor about any health questions or concerns.

Get the information you need, just when you need it.

bcbsok.com/okheei
Take the Health Risk Assessment Today!

In just 10 to 15 minutes, you can fill out the Health Risk Assessment (HRA) questionnaire and get a confidential report that outlines your health risks and strengths, and offers ideas for healthier living. The HRA includes questions about your diet, sleep and exercise habits, family health history, general safety and other topics.

It’s helpful – though not needed – to have these numbers before you begin the HRA:

- **Current height and weight**
- **Systolic (top number) and Diastolic (bottom number) of your blood pressure reading**
- **Total cholesterol level**
- **HDL cholesterol level**
- **Blood glucose level**
- **Waist measurement in inches**

Get the most from your health care benefit plan – sign up for Blue Access® for Members and take the HRA.
Here's How to Find the HRA

Sign up for Blue Access for Members (BAM), the secure member website that is the gateway to Blue Cross and Blue Shield of Oklahoma’s (BCBSOK) many online tools and resources.

1. Go to bcbsok.com and click the Log In tab.
2. Choose I'm a Member to log in to BAM.

If this is your first visit, click “Register Now” on the right to choose a User Name and Password. You’ll need to provide your Group and ID/Subscriber numbers, so have your BCBSOK ID card handy.

3. Under Quick Links, choose Take Your Health Risk Assessment. This brings you to a page with general information about the HRA. There are several ways to get to the HRA; the easiest is to click on the sentence in blue that says, “Take Your Health Risk Assessment Today.”

4. You are now on the Personal Health Manager home page. Under Know Your Risk, click Take Your Health Risk Assessment and begin the questionnaire.

Facts About the Health Risk Assessment

- Provides you with a personalized, confidential report with ideas to feel and look better as you improve your health.
- Completing the Health Risk Assessment will not affect your health care benefit coverage.
- Your results are kept confidential by BCBSOK.
- Your employer will receive a report showing the combined results for everyone in your company who participated. Your employer does not see your personal results.
- HRA information helps your employer decide on the medical benefits and programs that are best suited for employees and their families.

After you finish the HRA, check out the other health and wellness tools on Blue Access for Members.

If you take part in this program, your employer may be told that you participated for purposes of administering the program. Your employer will not receive any personal health information. Personal health information will be kept confidential by BCBSOK.
Prescription Drug Information
What you need to know about generic drugs

Generics Deliver

Safety –
Generic drugs are safe. Brand-name and generic drugs sold in the United States are approved and regulated by the Food and Drug Administration (FDA). The standards are the same. That’s safety you can count on.

Quality –
Generic drugs work the same way. When the FDA approves a generic drug, this means the generic drug is the same as its brand-name counterpart in dosage, performance, safety, strength, quality and usage.

Savings –
Generic drugs cost less. When the patent expires on a brand-name drug, other companies may begin making and selling the drug as a generic. Generic manufacturers don’t have to pay for the costly research and marketing that was done for the brand-name product. Lower prices mean more savings for you.

It’s a fact — generic drugs work in the same way as brand-name drugs. Don’t believe the myths. The proof is in the facts:

MYTH: Generic drugs are not as safe as brand-name drugs.
FACT: The FDA requires all drugs be safe and effective. Generics use the same active ingredients and work the same way in the body. This means generic drugs have the same risks and benefits as their brand-name counterparts.

MYTH: Generic drugs are not as strong as brand-name drugs.
FACT: The FDA requires generics to have the same quality and strength. Generic drugs work in the same way and in the same amount of time as brand-name drugs.

MYTH: Generic drugs are likely to cause more side effects than brand-name drugs.
FACT: There is no evidence that generic drugs cause more side effects. The FDA monitors reports of adverse drug reactions and has found no difference in the rates between generic and brand-name drugs.

MYTH: My doctor or pharmacy wants me to take generic drugs just to save money.
FACT: Your doctor and pharmacist want you to take drugs that are safe, effective and affordable. In most cases, generics are the best option when you compare price and quality.

MYTH: Brand-name drugs are made in modern manufacturing facilities and generic drugs are often made in substandard facilities.
FACT: The FDA won’t permit drugs to be made in substandard facilities. All generic manufacturing, packaging and testing sites must pass the same quality standards as those of brand-name drugs. The FDA conducts about 3,500 inspections a year to ensure standards are met.
In fact, brand-name manufacturers account for an estimated 50 percent of generic drug production. They frequently make copies of their own or other brand-name drugs and sell them without the brand name.

MYTH: Generic drugs cost less because they are inferior to brand-name drugs.

FACT: Generic drugs work in the same way and cost less. When a brand-name drug comes off patent, the generic products compete by offering lower prices. Generic manufacturers generally do not pay for costly advertising or significant research and development.


Learn more
Most medical conditions have at least one generic drug treatment option available. And new generics come out every year. Your doctor will know which generics are available and which ones could work best for you. Find out if there is a generic equivalent or a generic therapeutic alternative that’s right for you.

- Talk to your doctor or pharmacist. Taking a generic drug may give you the same results and cost less. To find generic drug costs under your pharmacy benefit, go to bcbsok.com.

- To view a free interactive module about generic drugs, log on to TotalHealthKnowledge.com. username: Generics password: BCBSOK

- Visit these helpful websites.
  www.fda.gov/Drugs/ResourcesForYou/Consumers/default.htm/consumer.htm
  www.consumerreports.org/health/bestbuy-drugs.htm

- For more information on the drug formulary, please contact customer service at the toll-free phone number listed on the back of your BCBSOK member ID card.

Your doctor and pharmacist want you to take drugs that are safe, effective and affordable. In most cases, generics are the best option when you compare price and quality. Generic drugs deliver a better value than brand-name drugs: they work the same way and cost less.

Blue Cross and Blue Shield of Oklahoma contracts with Prime Therapeutics to provide pharmacy benefit management and mail order pharmacy services. Blue Cross and Blue Shield of Oklahoma, as well as several other independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime Therapeutics.
Q. What is step therapy?
A. Step therapy is a clinical program that only applies to certain types of prescription medications. With step therapy, members will receive benefits for drugs subject to step therapy only after first trying alternative medications which have been determined to be safe, effective and less costly. In cases where alternative drugs are not appropriate for you to use, your physician can request an exception to the step therapy program.

Q. Why does my prescription benefit include step therapy?
A. Step therapy programs help manage the rising cost of prescription drugs, and the overall cost of health care. A “step” approach encourages the safe, cost-effective use of medication by first trying lower-cost medications whenever appropriate.

Q. How will step therapy affect me?
A. The vast majority of medications covered under your pharmacy benefit are not included in a step therapy program. Depending upon your specific benefit plan, a step therapy program may be in effect for one or more prescription drugs. Call the Customer Service number on the back of your ID card for more details.

When you present a prescription to the pharmacist for a drug subject to step therapy, that prescription will be immediately and automatically checked against your recent prescription claims history. If the available prescription history shows that you have already tried alternative, or first-line, drugs, your prescription may be automatically approved at the pharmacy.

In some instances, there may be no record of you receiving a first-line therapy, or medical diagnosis information may be needed. In these situations your pharmacist will receive a message to call Blue Cross and Blue Shield of Oklahoma (BCBSOK) Customer Service. Customer Service will then fax a prior authorization form to your doctor to complete and return to BCBSOK for review.

If you are prescribed a drug that is subject to step therapy, and believe that you have no pharmacy claims record of receiving a first-line drug, you may want to discuss other treatment options with your doctor to avoid any delay in your treatment.

Step therapy programs help manage the rising cost of prescription drugs, and the overall cost of health care.
If the available prescription history shows that you have already tried alternative, or first-line, drugs, your prescription may be automatically approved at the pharmacy.

Q. How are medications selected for the step therapy program?
A. A team of physicians and pharmacists reviews categories of medications that are potentially over-prescribed and where more cost-effective alternative medications are available. The team recommends that specific drugs be added to the step therapy program list whenever safe and clinically sound therapeutic options are available.

Q. What medications are included in the step therapy program?
A. Examples of drug categories that may be included in the step therapy program and sample medications include†*:

- **Antidepressants**: brand name selective serotonin reuptake inhibitors, such as Lexapro, Zoloft
- **Attention Deficit Hyperactivity Disorder (adults)**: Adderall, Concerta, Daytrana, Desoxyn, Dexedrine, Dextrostat, Focalin, Intuniv, Liquadd, Methyltin, Metadate CD, Ritalin, Strattera, Vyvanse
- **COX-2 inhibitors**: Celebrex
- **Diabetes**: Byetta, Victoza
- **Insomnia**: Ambien, Edluar, Lunesta, Rozerem, Sonata, Zolpidem
- **Lipid management**: Lipitor, Zetia
- **Osteoporosis**: Actonel, Boniva, Fosamax
- **Proton pump inhibitors**: AcipHex, Dexilant, Zegerid
- **Rheumatoid arthritis/psoriasis**: Amevive, Kineret, Simponi
- **Select high blood pressure medications, including the ARBs (Atacand, Avapro, Benicar, Cozaar (brand), Diovan, Micardis, Teveten)**, the ARB combination products, and Tekturna

†Additional categories may be added and the program may change from time to time.
*Third-party brand names are the property of their respective owners.

For information on the drug formulary, please contact customer service at the toll-free phone number listed on the back on your BCBSOK member ID card.
Prior Authorization

Q. What is prior authorization?
A. Prior authorization is a clinical program that only applies to certain types of prescription medications. Prescription medications subject to the prior authorization program will require pre-approval before they can qualify for coverage under the pharmacy benefit plan.

Q. Why does my prescription benefit include prior authorization?
A. Prior authorization programs are commonly used to help encourage the appropriate use of medications. Review and pre-approval of a select group of drugs can also help to reduce the chances of unnecessary drug treatment and help contain overall health care costs.

Q. How will prior authorization affect me?
A. The vast majority of medications covered under your pharmacy benefit are not subject to a prior authorization program. Depending upon your specific benefit plan, a prior authorization program may be in effect for one or more prescription drugs. Call the Customer Service number on the back of your ID card for more details.

If you or a family member receive a new prescription for a drug that is subject to the prior authorization program, your physician will need to submit an authorization request form. Your doctor should call the Customer Service number on the back of your ID card to receive the appropriate form. The form should be completed and faxed back to Blue Cross and Blue Shield of Oklahoma (BCBSOK) for review. When possible, ask your physician to obtain a confirmed authorization before you take your prescription to the pharmacy to be filled. If a prescription is presented to the pharmacist before an approval has been placed into the system, your pharmacist will receive a message to call BCBSOK Customer Service.

If you or a family member have a current prescription for a drug that has recently been added to the prior authorization program, in most instances, your physician will need to submit an authorization request form as described above.

Review and pre-approval of a select group of drugs can help to reduce the chances of unnecessary drug treatment and help contain overall health care costs.
The vast majority of medications covered under your pharmacy benefit are not subject to a prior authorization program.

Q. How does the program work?
If the prior authorization request is approved:
You will pay the appropriate amount based on your prescription drug benefit when you fill your prescription.

If the prior authorization request is not approved:
The medication will not be covered under your prescription drug benefit. You can still purchase the medication, but you will be responsible for the full cost. Or, you can talk to your doctor to find out if another drug might be right for you. Your course of treatment can only be determined by you and your doctor. As always, the appeal rights provided by your benefit plan are available to you.

Q. How are the medications subject to prior authorization determined?
A. A team of physicians and pharmacists reviews categories of medications that are potentially over-prescribed, frequently very expensive and that require regular monitoring to assure good results. The team takes into consideration the U.S. Food and Drug Administration’s (FDA) prescribing information, as well as nationally recognized clinical guidelines written by experts in the specialties that apply.

Q. What types of medications are included in the prior authorization program?
A. Examples of drug categories that may be included in the prior authorization program and sample medications include†*:

- **Anabolic steroids**: Anadrol, Oxandrin
- **Antifungal Agents**: Noxafil, Vfend
- **Erectile Dysfunction**: Caverject, Cialis, Edex, Levitra, Muse, Viagra
- **Growth hormones**: Genotropin, Humatrope, Norditropin, Nutropin AQ, Omnitrope, Saizen, Serostim, Tev-Tropin, Zorbtive
- **Hepatitis C medications**: Infergen, PegIntron, Pegasys
- **Narcolepsy**: Nuvigil, Provigil, Xyrem
- **Oral Fentanyl**: Actiq, Fentora, Onsolis

†Additional categories may be added and the program may change from time to time.
*Third-party brand names are the property of their respective owners.

For information on the drug formulary, please contact customer service at the toll-free phone number listed on the back on your BCBSOK member ID card.
Understanding Quantity Limits on Prescription Medications
Information for Members

Q: What is a quantity limit?
A: Your pharmacy benefit typically provides coverage for prescription drugs based on a 30-day supply. A quantity limit is a specific quantity of medication eligible for coverage as a 30-day supply or a 90-day mail-order supply. Quantity limits provide a clinical baseline for the recommended amount of medication that should be dispensed over a certain period of time. Limits are based upon FDA and manufacturer dosing recommendations, nationally recognized clinical guidelines and Blue Cross and Blue Shield of Oklahoma (BCBSOK) Pharmacy Advisory Committee review. For drugs covered under your benefit, medication quantities prescribed within these limits are automatically covered by your pharmacy benefit.

Q: Why does my prescription benefit include quantity limits?
A: Quantity limits for prescription medications play an important role in helping to keep health care affordable by improving the quality of pharmaceutical care, minimizing your health risks and assuring appropriate utilization when medications are dispensed.

Q: How will quantity limits affect me?
A: When you present a prescription to the pharmacist for a medication that is included under your benefit and subject to quantity limits, that prescription will immediately be covered if the quantity requested is at or below the allowed amount. If your prescription exceeds the quantity limit, the pharmacist will receive an online message that explains your pharmacy benefit limit for that specific medication. At this point, you can ask your pharmacist to fill your prescription for the exact quantity your benefit provides coverage for. Or if you prefer, and your medication is listed in the Quantity Limits section of the formulary posted at bcbsok.com, you can wait and ask your doctor to request coverage approval for a greater quantity.

If your prescription exceeds the usual recommended amount, you will need approval from BCBSOK to exceed your benefit limit. You can ask your physician to fax or mail a Quantity Override Request Form to BCBSOK to request coverage for additional medication.

The easiest way for your physician to obtain a Quantity Override Request Form is by visiting our website at bcbsok.com and clicking on the Provider section. If additional program information is needed, call the customer service number listed on the back of your ID card.

Q: What happens after my doctor submits an Override Request Form?
A: Physician requests are reviewed by both a clinical pharmacist and medical director within three business days after receiving a completed form. Override approvals are sent to you and your physician’s office. Your physician is responsible for letting you know if your request was approved. Once approved, your benefit will provide coverage for an additional, specified quantity of medication for a clinically appropriate period of time.
Denial notifications are mailed to both you and your physician. The notification letter includes the reason for denial and specific appeal information.

Q: What if my request is not approved?
A: If your request is denied, your physician may send an appeal to BCBSOK on your behalf. The appeal should include any helpful clinical information that would support why an additional quantity is medically necessary. All required appeal information, including the appropriate BCBSOK mailing address is included with each letter of denial.

Appeals may be sent to: Customer Service Appeals Coordinator
P.O. Box 3283
Tulsa, OK  74119-3283

As always, if you have a prescription for quantities in excess of your pharmacy benefit, you still may obtain those additional quantities, but you will be financially responsible for the full cost of the extra amount of the covered drug.

Q: What medications have quantity limits?
A: Examples of drug categories subject to quantity limits are:
- Migraine drugs (e.g. Immitrex, Maxalt and Zomig)
- Asthma inhalers and solutions (e.g. Advair, Albuterol, and Flovent)
- Nasal inhalers (e.g. Flonase, Nasarel and Nasonex)
- Osteoporosis agents (e.g. Actonel, Boniva and Fosamax)
- Ulcer medications (e.g. Nexium and Prevacid)
- Sexual dysfunction drugs (e.g. Cialis, Levitra and Viagra)

A complete drug list including the quantity limits that apply is available on our website at bcbsok.com. You may also obtain quantity limit information by calling the BCBSOK Customer Service number located on the back of your ID card.

Q: If my medication has quantity limits, is there an alternative medication I can take?
A: Talk to your doctor about what other treatment options may be available for you. Be sure to also discuss your quantity limits.

Q: How are the medications subject to quantity limits determined?
A: A team of pharmacists and physicians reviews categories of medications that are potentially over-prescribed, may not be intended for daily use or require routine monitoring to assure safety and good results. The reviewers take into consideration FDA dosing guidelines, nationally recognized clinical guidelines written by specialists and other generally accepted standards of practice when determining drug categories appropriate for quantity limits.

Q: What if I’m going on vacation?
A: If you are going on vacation, you may request a one-time vacation override by calling the BCBSOK customer service number listed on the back of your ID card. Important: while you may receive an early prescription refill, you will still have to wait the appropriate number of days before your next refill will be covered.

For more information on the drug formulary, please contact customer service at the toll-free phone number listed on the back of your BCBSOK member ID card.

bcbsok.com/okheei
PrimeMail® Mail Order
Information for Members

PrimeMail offers convenience with the highest standards of quality, safety and service for your prescription drug needs:

• **Convenience** — Delivery to your home or work with refill amounts and dates noted
• **Quality** — Each prescription is verified for accuracy and dispensed by a pharmacist who oversees every aspect of the process
• **Privacy** — Orders are handled discreetly and delivered in plain-labeled packaging with no indication of the contents
• **Safety** — A tamper-evident closure and secure packaging protect from breakage and temperature changes

How to Start Using PrimeMail
1. For each long-term medication prescribed for you, ask your physician to write a prescription for the maximum day supply your plan allows to be filled at PrimeMail.
2. Complete (in black ink) the PrimeMail Order Form
3. Mail the following items to the address listed on the order form:
   - Your completed PrimeMail Order Form
   - Your original physician-signed maximum day supply prescription*
   - The appropriate payment*

*You may submit more than one long-term prescription and payment at a time.

Commonly Asked Questions
Q: Why should I use PrimeMail to fill my prescriptions?
A: PrimeMail offers you convenient prescription delivery to your home or work with refill amounts and dates noted on your prescription label.

Q: How long does it take for my PrimeMail prescription order to arrive?
A: Prescriptions ordered through the mail will typically arrive via U.S. Mail in 10 to 14 days. You will receive your prescriptions faster if you order them online or by phone, because front-end mail time is eliminated. Your PrimeMail prescription label will indicate a date to refill your prescription that is three weeks prior to the end of your current supply.

PrimeMail offers convenient, discreet and secure delivery of prescription medications to your home or work.
Q: What if I want to order from PrimeMail, but I need my medication right away?
A: Ask your physician for two prescriptions — one for a 30-day supply to fill immediately at a local retail pharmacy and one for up to the maximum day supply allowed by your plan to fill at PrimeMail.

Q: Can I call directly to PrimeMail for refills?
A: Yes. You may call 877-35-PRIME (877-357-7463) to order refills through PrimeMail’s automated refill system. You may also reorder by visiting bcbsock.com or logging on to PrimeMail’s website at MyPrimeMail.com.

Q: How can I pay for my prescriptions?
A: You may pay by personal check, money order or credit card (Master Card, Visa, American Express or Discover). Paying with a credit card is the most convenient method for members, as PrimeMail can retain the information on file for future prescription orders.

Q: My physician wrote one 30-day prescription with two refills. Can you combine this and send me a 90-day supply?
A: No. PrimeMail must follow your physician’s directions exactly as they are written on the prescription. To receive 90 days of medication all at once, you will need a new prescription from your physician, rewritten for a 90-day supply with up to three refills.

Q: Can I get controlled substance prescriptions from PrimeMail?
A: Yes. Controlled substance prescriptions, such as Ritalin, Xanax, Valium or Vicodin, are available through PrimeMail. Your refill amounts may be limited for controlled substance medications in accordance with applicable pharmacy regulations.

Q: Should I request generic drugs for my prescription?
A: Yes. Ask your physician for the cost-effective generic alternatives to your brand-name medications to reduce cost without sacrificing the quality or effectiveness of the drug. Generic drugs must meet the same FDA standards for purity, safety, strength and effectiveness as brand-name drugs.

Q: Will PrimeMail pharmacists automatically substitute a generic medication?
A: PrimeMail will dispense FDA-approved generic equivalents when available and appropriate.

**Prescription Refill Options**
You can get medication refills by phone, online or through the mail. Remember to order three weeks before your current prescription is due to run out. PrimeMail provides the following convenient refill methods:

**Refill by Phone**
- Dial PrimeMail’s automated refill line at 877-35-PRIME (877-357-7463)
- Have your prescription number and credit card number information available; follow the system prompts to complete your refill order

**Refill Online**
- Log on to PrimeMail’s secure website at MyPrimeMail.com or through bcbsock.com
- Follow the website instructions to complete your refill order; you will need to have your prescription number and credit card information ready to enter

**Refill by Mail**
- Fill out the PrimeMail Refill Form included with your previous PrimeMail prescription delivery
- Include appropriate payment information

**Time and Money Saving Tips**
Ask for generics — they cost less and meet the same FDA requirements for safety, purity, strength and quality as brand-name drugs

Ensure the following necessary information is legible on your new prescription:
- The patient’s full first name and last name
- The exact daily dosage, strength and quantity
- The physician’s name, phone number and address

Ensure that your PrimeMail Order Form is complete — an incomplete form will cause a delay in processing your prescription

**Questions?**
If you have questions, please contact:
PrimeMail customer service at 877-35-PRIME (877-357-7463) or visit PrimeMail at MyPrimeMail.com — 24 hours a day, seven days a week.

bcbsock.com/okhee
HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Our Responsibilities

We are required by applicable federal and state law to maintain the privacy of your protected health information. “Protected health information” (PHI) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your PHI. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect November 10, 2008 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all PHI that we maintain, including PHI we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Protected Health Information

We use and disclose PHI about you for treatment, payment, and health care operations. Following are examples of the types of uses and disclosures that we are permitted to make.

Treatment: We may use or disclose your PHI to a physician or other health care provider providing treatment to you. We may use or disclose your PHI to a health care provider so that we can make prior authorization decisions under your benefit plan.

Payment: We may use and disclose your PHI to make benefit payments for the health care services provided to you. We may disclose your PHI to another health care plan, to a health care provider, or other entity subject to the federal Privacy Rules for their payment purposes. Payment activities may include processing claims, determining eligibility or coverage for claims, issuing premium billings, reviewing services for medical necessity, and performing utilization review of claims.

Health Care Operations: We may use and disclose your PHI in connection with our health care operations. Health care operations include the business functions conducted by a health insurer. These activities may include providing customer services, responding to complaints and appeals from members, providing case management and care coordination under the benefit plans, conducting medical review of claims and other quality assessment and improvement activities, establishing premium rates and underwriting rules. In certain instances, we may also provide PHI to the employer who is the plan sponsor of a group health plan.
We may also in our health care operations disclose PHI to business associates with whom we have written agreements containing terms to protect the privacy of your PHI. We may disclose your PHI to another entity that is subject to the federal Privacy Rules and that has a relationship with you for its health care operations relating to quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, case management and care coordination, or detecting or preventing health care fraud and abuse.

**Joint Operations:** We may use and disclose your PHI connected with a group health plan maintained by your plan sponsor with one or more other group health plans maintained by the same plan sponsor, in order to carry out the payment and health care operations of such an organized health care arrangement.

**On Your Authorization:** You may give us written authorization to use your PHI or to disclose it to another person and for the purpose you designate. If you give us an authorization, you may withdraw it in writing at any time. Your withdrawal will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your PHI for any reason except those described in this notice. We will make disclosures of any psychotherapy notes we may have only if you provide us with a specific written authorization or when disclosure is required by law.

**Personal Representatives:** We will disclose your PHI to your personal representative when the personal representative has been properly designated by you and the existence of your personal representative is documented to us in writing through a written authorization.

**Disaster Relief:** We may use or disclose your PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

**Health Related Services:** We may use your PHI to contact you with information about health related benefits and services or about treatment alternatives that may be of interest to you. We may disclose your PHI to a business associate to assist us in these activities.

We may use or disclose your PHI to encourage you to purchase or use a product or service by face-to-face communication or to provide you with promotional gifts.

**Public Benefit:** We may use or disclose your PHI as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law;
- for public health activities, including disease and vital statistic reporting, child abuse reporting, certain Food and Drug Administration (FDA) oversight purposes with respect to an FDA regulated product or activity, and to employers regarding work-related illness or injury required under the Occupational Safety and Health Act (OSHA) or other similar laws;
- to report adult abuse, neglect, or domestic violence;
- to health oversight agencies;
- in response to court and administrative orders and other lawful processes;
- to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- to avert a serious threat to health or safety;
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- to correctional institutions regarding inmates; and
- as authorized by and to the extent necessary to comply with state worker’s compensation laws.

We will make disclosures for the following public interest purposes, only if you provide us with a written authorization or when disclosure is required by law:

- to coroners, medical examiners, and funeral directors;
- to an organ procurement organization, and
- in connection with certain research activities.

**Use and Disclosure of Certain Types of Medical Information.** For certain types of PHI we may be required to protect your privacy in ways more strict than we have discussed in this notice. We must abide

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1 A “business associate” is a person or entity who performs or assists Blue Cross Blue Shield of Oklahoma with an activity involving the use or disclosure of medical information that is protected under the Privacy Rules.
by the following rules for our use or disclosure of certain types of your PHI:

- **Communicable or Noncommunicable Disease.** Unless otherwise provided by law, we may not disclose information or records which identify any person who has or may have any communicable or noncommunicable disease which is required to be reported pursuant to 63 O.S. 2001, Sections 1-501 through 1-532.1, or information and records of any disease, unless authorized by law or the disclosure is to you, or a health care provider for diagnosis or treatment, or with your written authorization, provided such an authorization contains a notice in bold typeface that the information authorized for release may include records which may indicate the presence of a communicable or noncommunicable disease. These requirements do not apply to written authorizations to disclose information to the Social Security Administration.

- **HIV Test Information.** We may not disclose the result of any HIV test unless authorized by law or the disclosure is to you, your personal representative, a physician or other person involved in your treatment, or pursuant to your written authorization.

- **Mental Health and Alcohol or Substance Abuse Treatment Information.** We may not disclose your mental health and alcohol or substance abuse treatment information unless it is to you (except information contained in notes recorded by a mental health professional regarding conversations during a counseling session), or unless the disclosure is authorized by law or you provide us with written permission to disclose.

- **Genetic Information.** We may not use or disclose your genetic information unless the use or disclosure is authorized by law or you provide us with written permission to disclose such information.

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**Individual Rights**

You may contact us using the information at the end of this notice to obtain the forms described here, explanations on how to submit a request, or other additional information.

**Access:** You have the right, with limited exceptions, to look at or get copies of your PHI contained in a designated record set. A “designated record set” contains records we maintain such as enrollment, claims processing, and case management records. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. You must make a request in writing to obtain access to your PHI and may obtain a request form from us. If we deny your request, we will provide you a written explanation and will tell you if the reasons for the denial can be reviewed and how to ask for such a review or if the denial cannot be reviewed.

**Disclosure Accounting:** You have the right to receive a list of instances for the 6-year period, but not before April 14, 2003, in which we or our business associates disclosed your PHI for purposes, other than treatment, payment, health care operations, or as authorized by you, and for certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. We will provide you with more information on our fee structure at your request.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your PHI. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is in writing.

**Confidential Communication:** You have the right to request that we communicate with you about your PHI by alternative means or to alternative locations. You must make your request in writing. This right only applies if the information could endanger you if it is not communicated by the alternative means or to the alternative location you want. You do not have to explain the basis for your
request, but you must state that the information could endanger you if the communication means or location is not changed. We must accommodate your request if it is reasonable, specifies the alternative means or location, and provides satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right, with limited exceptions, to request that we amend your PHI. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended and the originator remains available or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement to be attached to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

Right to Receive a Copy of the Notice: You may request a copy of our notice at any time by contacting the Privacy Office or by using our Web site, www.bcbsok.com. If you receive this notice on our web site or by electronic mail (e-mail), you are also entitled to request a paper copy of the notice.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.

If you are concerned that we may have violated your privacy rights, you may complain to us using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services; see information at its Web site: www.hhs.gov. If you request, we will provide you with the address to file your complaint with the U.S. Department of Health and Human Services.

We support your right to the privacy of your PHI. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact:    Director, Privacy Office  
            Blue Cross Blue Shield of Oklahoma  
            P.O. Box 804836  
            Chicago, IL 60680-4110

You may also contact us using the toll-free number located on the back of your BCBSOK’s member identification card.
Important Notices

I. Initial Notice About Special Enrollment Rights and Pre-existing Condition Exclusion Rules in Your Group Health Plan

A federal law called Health Insurance Portability and Accountability Act (HIPAA) requires that we notify you about two very important provisions in the plan. The first is your right to enroll in the plan under its “special enrollment provision” without being considered a late applicant if you acquire a new dependent or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons. Second, this notice advises you of the plan’s pre-existing condition exclusion rules that may temporarily exclude coverage for certain pre-existing conditions that you or a member of your family may have. Section I of this notice may not apply to certain self-insured, non-federal governmental plans. Contact your employer or plan administrator for more information.

A. Special Enrollment Provisions

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program) If you are declining enrollment for yourself or your eligible dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if you move out of an HMO service area, or the employer stops contributing toward your or your dependents’ other coverage). However, you must request enrollment within 31 days after your or your dependents’ other coverage ends (or move out of the prior plan’s HMO service area, or after the employer stops contributing toward the other coverage).

Loss of Coverage For Medicaid or a State Children's Health Insurance Program If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children’s health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents’ coverage ends under Medicaid or a state children’s health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for State Premium Assistance for Enrollees of Medicaid or a State Children’s Health Insurance Program If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children’s health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents’ determination of eligibility for such assistance.

You or your spouse or dependents may also have special enrollment rights in another group health plan at the time a claim is denied as a result of a lifetime limit on all benefits, if you request enrollment within 30 days after the claim has been denied.

To request special enrollment or obtain more information, call Customer Service at the phone number on the back of your Blue Cross and Blue Shield ID card.

B. Pre-existing Condition Exclusion Rules

Most health plans impose pre-existing condition exclusions. This means that if you have a medical condition before coming to our plan you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period before your enrollment date. Generally, this six-month period ends the day before your coverage becomes
effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins. “Waiting period” generally refers to a delay between the first day of employment and the first day of coverage under the plan. The pre-existing condition exclusion does not apply to pregnancy or to an individual under the age of 19.

This pre-existing condition exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days you had prior “creditable coverage.” Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, you have a right to request one from your prior plan or issuers. We will help you obtain one from your prior plan or issuer, if necessary. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

For more information about the pre-existing condition exclusion and creditable coverage rules affecting your plan, call Customer Service at the phone number on the back of your Blue Cross and Blue Shield ID card.

II. Additional Notices

Other federal laws require we notify you of additional provisions of your plan.

A. Enrollment Notice for Adult Children Under Age 26

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in the plan. Individuals may request enrollment for such children during an enrollment period that continues for at least 30 days, beginning not later than the first day of the first plan year beginning on or after September 23, 2010. If an individual is timely enrolled, enrollment will be effective retroactively to the first day of the first plan year, beginning on or after September 23, 2010. For more information, call Customer Service at the phone number on the back of your Blue Cross and Blue Shield ID card.

Special Rule for grandfathered group health plans (if applicable) – The plan may exclude an adult child who has not obtained age 26 from coverage only if the adult child is eligible to enroll in an eligible employer-sponsored health plan other than a group health plan of a parent.

B. Notices of Right to Designate a Primary Care Provider (for Non-Grandfathered Health Plans Only)

For plans that require or allow for the designation of primary care providers by participants or beneficiaries:

If the plan generally requires or allows the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, call Customer Service at the phone number on the back of your Blue Cross and Blue Shield ID card.

For plans that require or allow for the designation of a primary care provider for a child:

For children, you may designate a pediatrician as the primary care provider.

For plans that provide coverage for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider:

You do not need prior authorization from the plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For a list of participating health care professionals who specialize in pediatrics, obstetrics or gynecology, call Customer Service at the phone number on the back of your Blue Cross and Blue Shield ID card.
Health Insurance Fraud
What You Should Know

Fraud Affects Everyone
Fraud may cost the health care industry more than $200 billion each year. As a member of Blue Cross and Blue Shield of Oklahoma (BCBSOK), this fraud may cause you to face rising premiums, increased copayments and deductibles, and the elimination of certain benefits.

Don’t Be a Victim
In addition to losing money through fraud, members have also experienced physical and mental harm as a result of health care fraud schemes in which a provider performed unnecessary or dangerous procedures.

Identifying Fraud
Commonly identified schemes involving providers include:

• Misrepresenting Services – Intentionally billing procedures under different names or codes to obtain coverage for services that aren’t included in a member’s plan.

• Upcoding – Deliberately charging for more complex or more expensive services than those actually provided.

• Non-rendered and/or “Free” Services – Some providers intentionally bill for tests or services never provided. This can also mean that the provider offered “free” services to bill the insurance company for services not performed or needed.

• Kickbacks, Bribes or Rebates – Referring patients to a provider or facility in which the referring provider has a financial interest.

Commonly identified member schemes include:

• Identity Swapping – Allowing an uninsured individual to use a member’s insurance card.

• Identity Theft – Using false identification to gain employment and the health insurance benefits that come with it.

• Non-eligible Members – Adding someone to a policy who is not eligible, or failing to remove someone when that person becomes ineligible.

• Prescription Medicine Abuse and Diversion – Controlled substances can be obtained through deception or dishonesty for personal use or sale “on the street.” Prescription medications can be obtained through doctor-shopping, visiting several emergency rooms, or stealing doctors’ prescription pads.

Fraud increases costs and decreases benefits.
Fighting Fraud

BCBSOK offers these tips:

- Know your own benefits and scope of coverage.
- Review all Explanation of Benefits (EOB) forms. Make sure the exams, procedures and tests billed were the ones you actually had with the provider who treated you.
- Understand your responsibility to pay deductibles and copayments, and what you can and cannot be balanced billed for once your claim has been processed.
- Guard your health insurance card and personal insurance information. Notify BCBSOK immediately if your card or insurance information is lost or stolen.
- Sign and date only one claim form per office visit.
- Never lend your member ID card to another person.
- Don’t give out insurance or personal information if services are offered as “free.” Be sure you understand what is “free” and what you or your employer will be charged for.
- Ask your doctors exactly what tests or procedures they want you to have and why. Ask why the tests or procedures are necessary before you have them.
- Be sure any referrals you receive from your network provider are to other network doctors or facilities. If you’re not sure, ask.
- Monitor your prescription utilization via the BCBSOK website or your Pharmacy Benefit Manager (PBM). Make sure the medications billed to your insurance are accurate.
Preventing Health Care Fraud
BCBSOK created the Special Investigations Department (SID) to fight fraud and help lower health care costs. The staff includes individuals with medical, insurance and law enforcement backgrounds, as well as data analysts experienced in detecting fraudulent billing schemes. The SID aggressively investigates reports of fraud and refers appropriate cases for criminal prosecution.

Fraud Isn’t Fair. Help Us Fight It.
Reducing health care fraud is a collaborative effort between BCBSOK, its providers and its members. We encourage you to report any suspected incidence of fraud by calling our Health Care Fraud Hotline, completing a form online or sending us a note in the mail. Suspicions of fraud can be reported to the SID anonymously.

Three Ways To Report Fraud To BCBSOK
The SID is here to help you. You can contact the SID in any of the following ways:

1. (800) 543-0867
   The toll-free Fraud Hotline operates 24 hours a day, seven days a week. You can remain anonymous or provide information if you want to be contacted by a member of the SID.

2. bcbsok.com/sid/reporting
   This website address links to an online fraud reporting form that can be completed and sent to the SID electronically.

3. U.S. Mail
   You can write the SID at:
   Blue Cross and Blue Shield of Oklahoma
   Special Investigations Department
   P.O. Box 3283
   Tulsa, Oklahoma 74102-3283

Our Special Investigations Department is one of the most effective in the industry.