

**BCBSOK JANUARY 1, 2010 TRANSITION
OKLAHOMA HIGHER EDUCATION EMPLOYEE INSURANCE GROUP
FREQUENTLY ASKED QUESTIONS**

GENERAL QUESTIONS

- **Can participants have dual coverage with primary coverage under Blue Cross and Blue Shield of Oklahoma (BCBSOK) and another Blue Cross plan they are on through their spouse?** Yes, BCBSOK coordinates with other Group Blue Cross Plans (including Oklahoma) the same way it would with another carrier.
- **How can I find a physician or hospital that is in the BCBSOK network?** To find a PPO provider, you can access the online provider directory at www.bcbsok.com and click on the “Search for doctors, dentists, hospitals and other health care providers with our Provider Finder” link on the left side of the page. The Network Type for your group is “BlueChoice®”. To locate a provider outside of Oklahoma, click on the same link and then in the bottom left corner click on “Find U.S. Providers Outside of Oklahoma” in the More Searches section.
- **What foreign countries are in the Blue Cross Network?** BCBSOK has contracted providers in over 185 countries outside the US. To locate those providers you can call 1.800.810.BLUE or visit the Provider Finder on our Web site at www.bcbsok.com. Please note that you must have a member number to access the directory for the BlueCard WorldWide® network, so you won’t be able to access this function until you have received your Blue Cross and Blue Shield ID Card.
- **Can participants go to a nationally recognized treatment center such as MD Anderson or the Mayo Clinic and have in-network benefits?** Yes, as long as those treatment centers are in the BlueCard® PPO Network. Both MD Anderson and Mayo are in the BlueCard PPO Network. To find network providers, please visit our Web site at www.bcbsok.com.
- **How do I find a Network Dentist?** Please visit www.bcbsok.com and go to “Search for doctors, dentists, hospitals, and other health care providers with our Provider Finder”. Click on “Find a Dentist” at the bottom left corner and select the network: BlueCare® Dental (formerly LINCS Dental Connection Traditional).
- **Will the lifetime max start from \$0 for participants/dependents that have or have had Blue Cross coverage?** Yes, lifetime max will begin at \$0 regardless of previous or current other coverage.
- **Will the lifetime max ever be increased?** We will consider increasing the lifetime maximum for the group after one year of being on the BCBSOK plan.
- **What services require precertification? What is the process?** Any inpatient hospital stay, home health or hospice care, skilled nursing facility services, and private duty nursing care. Some outpatient surgeries and diagnostic imaging services require precertification as well.

If you use a BlueChoice PPO provider in Oklahoma for your services, your provider will automatically request precertification for you. The member is responsible for obtaining precertification for services received outside of Oklahoma or from an out of network provider.
- **Are dependent children still covered up to the age of 25 regardless of student status?**
Yes

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- **Can dependents be enrolled in dental or vision if they are not covered on the BCBSOK medical plan?** Yes
- **Will I have to file my own claims for medical services?** No, providers that are in-network will file the claims with BCBSOK. If a provider is out-of-network, they may require you to file the claim yourself. Claim forms can be found at www.bcbsok.com and should be mailed to: Blue Cross and Blue Shield of Oklahoma, PO Box 3282, Tulsa, OK 74102-3282.
- **When will I receive my ID card?** You will receive new ID cards on or before January 1, 2010. For single coverage you will receive one card; for family coverage you will receive two cards. Additional cards can be ordered online or by calling customer service. ID cards will list the employee's name only. Spouse and dependent information will not be on the card.
- **If I don't sign-up for coverage when first eligible and later want to enroll, will there be any restrictions?** Yes, if you don't enroll during the upcoming/initial enrollment period (January 1, 2010), you cannot sign-up until the next annual open enrollment which occurs each year, unless you have a qualified status change during the plan year.

In addition, if you do not enroll during this time (January 1, 2010), you may also be subject to pre-existing conditions. Blue Cross and Blue Shield has waived pre-existing conditions for all employees and eligible dependents that enroll for January 1, 2010.

PRE-EXISTING CONDITIONS

Here is more information on pre-existing conditions:

A condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending on the enrollment date. In order to be taken into account, the medical advice, diagnosis, care, or treatment must have been recommended by or received from an individual licensed or similarly authorized to provide such services under state law and operating within the scope of practice authorized by the state law. A pre-existing condition does not include pregnancy, nor can it be applied to a newborn or adopted child under age 18, as long as the child became covered under the certificate within 31 days of birth or adoption.

Pre-existing Condition Exclusion

A 12-month or 18-month period during which no benefits will be provided for a condition for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period before the enrollment date.

Your benefits under this certificate are subject to a pre-existing condition exclusion period. However, the pre-existing condition exclusion will only apply to you and/or a dependent if the following conditions are met:

- **Six-month Look-back Rule**
 - The pre-existing condition exclusion must relate to a condition (whether physical or mental, and regardless of the cause of the condition) for which medical advice,

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diagnosis, care, or treatment was recommended or received within the six-month period ending on the subscriber's enrollment date.

- In order to be taken into account, the medical advice, diagnosis, care, or treatment must have been recommended or received from an individual licensed or similarly authorized to provide such services under state law and operating within the scope of practice authorized by state law.
 - The six-month look-back period is based on the six-month "anniversary date" of the enrollment date.
- **Length of Pre-existing Condition Exclusion Period**
- The exclusion period cannot extend for more than 12 months (18 months for late enrollees) after the enrollment date. The 12-month or 18-month "look forward" period is also based on the anniversary date of the enrollment date.
- **Reduction of Pre-existing Condition Exclusion Period by Prior Coverage**
- In general, the pre-existing condition exclusion period must be reduced by the individual's days of "creditable coverage" as of the enrollment date. Creditable coverage includes coverage from a wide range of specified sources, including group health plans, most individual health insurance coverage, Medicare, and Medicaid. However, days of creditable coverage that occurs before a significant break in coverage (63 or more consecutive days) will not be counted in reducing the pre-existing condition exclusion period.
 - In addition, the pre-existing condition exclusion period will be waived for an individual with prior creditable coverage through a health maintenance organization, and who enrolls under this certificate without a significant break in coverage.
- **Elimination of Pre-existing Condition Exclusion for Pregnancy and for Certain Children**
- A pre-existing condition exclusion cannot apply to pregnancy. In addition, a pre-existing condition exclusion period cannot be applied to a newborn, an adopted child under age 18, or a child placed for adoption under age 18, if the child becomes covered within 31 days of birth, adoption, or placement for adoption.

Notice to Subscribers

The plan may only impose a pre-existing condition exclusion with respect to a subscriber by notifying the subscriber, in writing, of the existence and terms of any pre-existing condition exclusion under the plan and of the rights of the subscriber to demonstrate creditable coverage. The plan will assist the subscriber in obtaining a certificate of coverage from any prior health plan or issuer, if necessary.

The plan may, without waiving the above provisions, elect to provide benefits for care and services while awaiting the decision of whether or not the care and services fall within the above pre-existing condition limitations. If it is later determined that the care and services are excluded from the subscriber's coverage, the plan will be entitled to recover the amount it has allowed for benefits under this certificate. The subscriber must provide the plan with all documents it needs to enforce its rights under this provision.

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MEDICAL / DENTAL BENEFIT QUESTIONS (Answers are based on use of in-network providers)

- **What will the doctor's office co-pay be?** \$25
- **What will the annual deductible become?** Deductible amounts will remain the same as what they were on HealthChoice in 2009.
- **Do doctor's office visits and pharmacy co-pays apply to the deductible or out-of-pocket maximum?** No, they do not apply and will remain separate.
- **Will Blue Cross pay less of the allowed charges than HealthChoice (co-insurance levels)?** No, Blue Cross also pays 80% of allowed charges after the annual deductible has been met.
- **What are the mental health benefits for 2010?** Mental health will be paid as any other illness.
- **Is smoking cessation covered?** Yes, two full 90 day courses of any FDA approved tobacco cessation drug are covered. Over the counter drugs and other smoking cessation related services are not covered.
- **What is covered for family planning?** Some services related to the diagnosis and treatment of infertility are covered, as well as prescription drugs for treatment of infertility. Family planning services provided in a physician's office, including surgical procedures for sterilization, injections, IUDs, and internally time-released implants are also covered. Prescription drugs for birth control are covered under the pharmacy benefit.

Artificial insemination, embryo transplant, invitro fertilization, surrogate parenting, ovum transplant, donor semen, gamete intrafallopian transfer (gift), zygote intrafallopian transfer (zift), and reversal of voluntary sterilization are all excluded.

- **Are benefits under therapeutic/chiropractic services – mechanical traction CPT code 97012 and electric muscle stimulation CPT code 97014 covered by BCBSOK?** No, they are not a covered benefit. For more information regarding medical policy for these procedures you can visit www.bcbsok.com and go to "providers" then "medical policy".
- **Do I have to select/designate a primary care physician (PCP)?** No, this is not a managed care or HMO plan, so you can select your provider at the time of service.
- **Are referrals required to specialists or can I self-refer?** BCBSOK does not require a primary care physician referral to see a specialist; however, *the specialist may require a referral from your primary physician before seeing you.*
- **If my child has met part of the waiting period for orthodontia, will I have to start over with Blue Cross?** BCBSOK will waive the waiting period for orthodontia for those who enroll on January 1, 2010. For those that enroll after 1/1/10, there will be a 12 month waiting period for orthodontia.

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- **If I have specific questions on whether specific medical treatment will be covered under our plan, who should I contact?** Once you are enrolled in the plan (after January 1, 2010) you may contact BCBSOK directly using the customer service phone number listed on the back of your ID card. They will ask for your name and member id in order to reference your plan's coverage information.

PRESCRIPTION QUESTIONS

- **What insurance carrier administers the Rx plan?** The prescription drug plan is administered by Prime Therapeutics. If you elect BCBSOK medical coverage, you automatically are covered under the prescription drug plan.
- **Will my prescription co-pays change for 2010?** No, they will remain the same; however BCBSOK's formulary (drug list) does differ from HealthChoice so your co-pay amount may change due to how your specific prescription drug is classified.
- **How are mail-order prescriptions covered?** Members will pay one co-pay for a 90-day supply of maintenance medications purchased through mail order.
- **What medications are excluded from the Blue Cross plan?** BCBS does not have a specific exclusion list for just medications. Any medication used to treat conditions listed on our standard exclusion and limitations list would not be a covered benefit.
- **Does our plan have a prescription drug formulary?** Yes, the Prime Therapeutics plan utilizes a formulary. A formulary is a list of brand-name prescription drugs that are available through Prime Therapeutics at the "preferred brand" copayment. If you fill a brand-name prescription drug that is not on the formulary, you pay the "non-preferred brand" copayment. To see if your prescription is on the formulary or if there is a generic available, access our website at www.bcbsok.com, click on "Members" then "Prescription Drug Information" to find the BCBSOK drug formulary.
- **If my doctor says I cannot take a drug that is Generic or Preferred, can I get the Non Preferred drug at the Generic or Preferred co-pay?** No, you would pay the applicable co-pay for a non-preferred prescription drug.
- **If a drug is not listed on the formulary, is it covered?** Yes, as long as the prescription is FDA approved for your covered medical condition. Due to the numerous drugs on the market today, the formulary (drug list) only includes all of Tier 2 drugs and a partial listing of Tier 1 and 3 drugs.
- **What card do I need to show at the Pharmacy? Is it the same as my medical insurance card?** You will receive an ID card from BCBSOK which is for both your medical and prescription drug coverage.
- **How can I find a participating retail pharmacy in my area?** Prescriptions can be filled at any participating retail pharmacy and through the Prime Therapeutics mail order program. To find a participating pharmacy, visit www.bcbsok.com.

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- **What is the process for step therapy and preauthorization?** BCBSOK requires pre-authorization or step-therapy on some medications. After January 1, 2010 when your BCBSOK benefits become effective, there will be a 90-day grace period when you will not be required to obtain pre-authorization or undergo step therapy. After the 90-day grace period, approximately April 1, 2010, pre-authorization and step therapy will be required for certain drugs. Example: If you are currently taking Prevacid, or will start taking Prevacid between January 1, 2010 and March 31, 2010, you will not be required to obtain pre-authorization or undergo step therapy for this medication. However, if after the first 90 days of the BCBSOK plan (beginning April 1, 2010) you begin taking Prevacid, or if you wait until that time to get an existing prescription refilled for the first time in the year, you will be required to start the pre-authorization and/or step therapy process.
- **What is step therapy?** Step therapy helps ensure your safety while managing the cost of specific medications. Step therapy typically targets high-cost drugs and drug classes of drugs, which should have careful assessment of patient selection or prior treatment before providing the drug. Drugs included in this program require that a prerequisite drug be tried before the step therapy drug will be approved for coverage. If the member meets the initial step therapy criteria, then the requested medication will be covered automatically under the member's current prescription benefit. To see a list of drugs and drug groups subject to step therapy, review BCBSOK's drug formulary. Visit www.bcbsok.com, click on "Members", then "Prescription Drug Information".
- **On the drug formulary, what does "SP" stand for?** On the BCBSOK drug formulary, "SP" stands for "Specialty Pharmacy". Specialty pharmacy medications are used to treat chronic and/or complex medical conditions such as multiple sclerosis, hepatitis C, and rheumatoid arthritis. BCBSOK's specialty pharmacy provider is Triessent. Specialty drugs can be obtained for a maximum of a 30 day supply and they are sent directly from Triessent to your home or to your health care provider.