BlueCross BlueShield of Oklahoma

The BlueCard® Program Provider Manual

December 2014

This information does not constitute, and is not intended as, legal or financial advice.

Table of Contents

1. Introduction: BlueCard Program Makes Filing Claims Easy

As a participating provider of Blue Cross and Blue Shield of Oklahoma (BCBSOK) you may render services to patients who are National Account members of other Blue Plans, and who travel or live in Oklahoma.

This manual describes the advantages of the program, and provides information to make filing claims easy. This manual offers helpful information about:

- Identifying members
- Verifying eligibility
- Obtaining pre-certifications/pre-authorizations
- Filing claims
- Who to contact with questions

2. What is the BlueCard Program?

2.1 Definition

BlueCard is a national program that enables members of one Blue Plan to obtain healthcare service benefits while traveling or living in another Blue Plan's service area. The program links participating healthcare providers with the independent Blue Plans across the country and in more than 200 countries and territories worldwide through a single electronic network for claims processing and reimbursement.

The program lets you submit claims for patients from other Blue Plans, domestic and international, to your local Blue Plan.

Your local Blue Plan is your sole contact for claims payment, adjustments and issue resolution.

2.2 BlueCard Program Advantages to Providers

The BlueCard Program lets you conveniently submit claims for members from other Blue Plans, including international Blue Plans, directly to BCBSOK and we will be your only point of contact for all of your claims-related questions.

BCBSOK continues to experience growth in out-of-area membership because of our partnership with you. That is why we are committed to meeting your needs and expectations.
Working together, we can ensure your patients will have a positive experience at each visit.

2.3 Products included in BlueCard

A variety of products and claim types are eligible to be delivered via BlueCard, however not all Blue Plans offer all of these products to their members. Currently BCBSOK offers products indicated by the asterisk below, however you may see members from other Blue Plans who are enrolled in the other products:

- Traditional (indemnity insurance)*
- PPO (Preferred Provider Organization) *
- EPO (Exclusive Provider Organization)
- POS (Point of Service)
- HMO (Health Maintenance Organization) *
    - HMO claims are eligible to be processed under the BlueCard Program or through the Away From Home Care Program.
- BlueCard Worldwide Program claims
- GeoBlue Expat claims
- Medigap – Medicare Complementary/Supplemental*
- Medicaid: payment is limited to the member's Plan's state Medicaid reimbursement rates. These cards will not have a suitcase logo.
- Stand-alone SCHIP (State Children's Health Insurance Plan) if administered as part of Medicaid: payment is limited to the member's Plan's state Medicaid reimbursement rates. These member ID cards also do not have a suitcase logo. Standalone SCHIP programs will have a suitcase logo.
- Standalone vision
- Standalone prescription drugs

NOTE: standalone vision and standalone self-administered prescription drugs programs are eligible to be processed through BlueCard when such products are not delivered using a vendor. Consult claim filing instructions on the back of the ID cards.

NOTE: definitions of the above products are available in the Glossary of Terms section of this Manual

2.4 Products Excluded from the BlueCard Program

The following claims are excluded from the BlueCard Program:

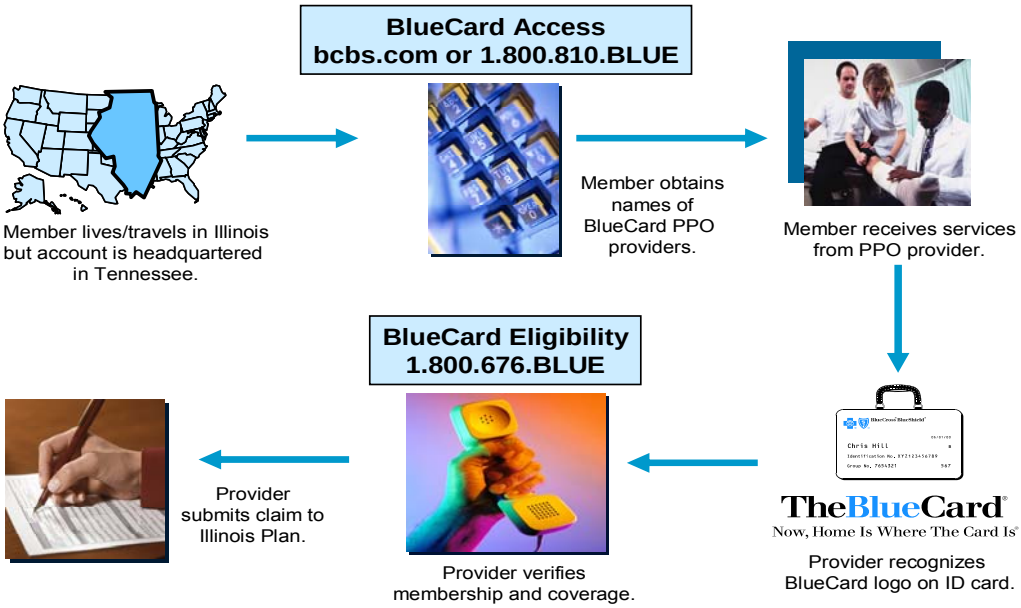
- Stand-alone dental
- Vision delivered through an intermediary model (using a vendor)
- Self-administered prescription drugs delivered through an intermediary model (using a vendor)

- Medicaid and SCHIP that is part of the Medicaid program
- Medicare Advantage*
- The Federal Employee Program (FEP)

Please follow BCBSOK billing guidelines.

*Medicare Advantage is a separate program from BlueCard, and delivered through its own centrally-administered platform. However since you might see members of other Blue Plans who have Medicare Advantage coverage, there is a section on Medicare Advantage claims processing in this manual.

3. How the BlueCard Program Works



In the example above, suppose a member has PPO coverage through BlueCross BlueShield of Tennessee. There are two scenarios where that member might need to see a provider in another Plan's service area, in this example, Illinois:

1) if the member was traveling in Illinois or

2) if the member resided in Illinois and had employer-provided coverage through BlueCross BlueShield of Tennessee.

In either scenario, the member can obtain the names and contact information for BlueCard PPO providers in Illinois by calling the BlueCard Access Line at 1.800.810.BLUE (2583). The member also can obtain information on the Internet, using the BlueCard National Doctor and Hospital Finder available at www.bcbs.com.

NOTE: members are not obligated to identify participating providers through either of these methods but it is their responsibility to go to a PPO provider if they want to access PPO in-network benefits

When the member makes an appointment and/or sees an Illinois BlueCard PPO provider, the provider may verify the member's eligibility and coverage information via the BlueCard Eligibility Line at 1.800.676.BLUE (2583). The provider also may obtain this information via a HIPAA electronic eligibility transaction if the provider has established electronic connections for such transactions with the local Plan, Blue Cross and Blue Shield of Illinois.

After rendering services, the provider in Illinois files a claim locally with Blue Cross and Blue Shield of Illinois. Blue Cross and Blue Shield of Illinois forwards the claim to BlueCross BlueShield of Tennessee that adjudicates the claim according to the member's benefits and the provider's arrangement with the Illinois Plan. When the claim is finalized, the Tennessee Plan issues an

explanation of benefit or EOB to the member, and the Illinois Plan issues the explanation of payment or remittance advice to its provider and pays the provider.

3.1 How to Identify members

3.1.1 Member ID Cards

When Members of Blue Plans arrive at your office or facility, be sure to ask them for their current Blue Plan membership identification card.

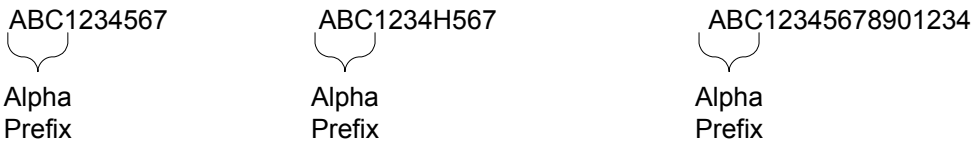
The main identifier for out-of-area members is the alpha prefix. The ID cards also may have:

- PPO in a suitcase logo, for eligible PPO members
- PPOB in a suitcase logo, for PPO members with access to the BlueCard PPO Basic network
- Blank suitcase logo

Important facts concerning member IDs:

- A correct member ID number includes the alpha prefix (first three positions) and all subsequent characters, up to 17 positions total. This means that you may see cards with ID numbers between 6 and 14 numbers/letters following the alpha prefix.
- Do not add/delete characters or numbers within the member ID.
- Do not change the sequence of the characters following the alpha prefix.
- The alpha prefix is critical for the electronic routing of specific HIPAA transactions to the appropriate Blue Plan.
- Members who are part of the FEP will have the letter "R" in front of their member ID number.

Examples of ID numbers:



As a provider servicing out-of-area members, you may find the following tips helpful:

- Ask the member for the most current ID card at every visit. Since new ID cards may be issued to members throughout the year, this will ensure you have the most up-to-date information in the member's file.
- Verify with the member that the ID number on the card is not his/her Social Security Number. If it is, call the BlueCard Eligibility line 1.800.676.BLUE (2583) to verify the ID number.
- Make copies of the front and back of the member's ID card and pass this key information on to your billing staff.
- Remember: member ID numbers must be reported exactly as shown on the ID card and must not be changed or altered. Do not add or omit any characters from the member ID numbers. Alpha Prefix

The three-character alpha prefix at the beginning of the member's identification number is the key element used to identify and correctly route claims. The alpha prefix identifies the Blue Plan or National Account to which the member belongs. It is critical for confirming a patient's membership and coverage.

To ensure accurate claim processing, it is critical to capture all ID card data. If the information is not captured correctly, you may experience a delay with claim processing. Please make copies of the front and back of the ID card, and pass this key information to your billing staff.

- Do not make up alpha prefixes.
- Do not assume that the member's ID number is the social security number. All Blue Plans replaced Social Security numbers on member ID cards with an alternate, unique identifier.

Sample ID Card

BlueCard ID cards have a suitcase logo, either as an empty suitcase or as a PPO in a suitcase.

The PPO in a suitcase logo indicates that the member is enrolled in a PPO product.

The PPOB in a suitcase logo indicates that the member has selected a PPO or EPO product, from a Blue Plan, and the member has access to a new PPO network, referred to as BlueCard PPO Basic.

Providers will be reimbursed for covered services in accordance with your PPO Basic contract with BCBSOK.

The empty suitcase logo indicates that the member is enrolled in one of the following products: Traditional, HMO or POS. For members having traditional or HMO coverage, you will be reimbursed according to BCBSOK traditional provider contract

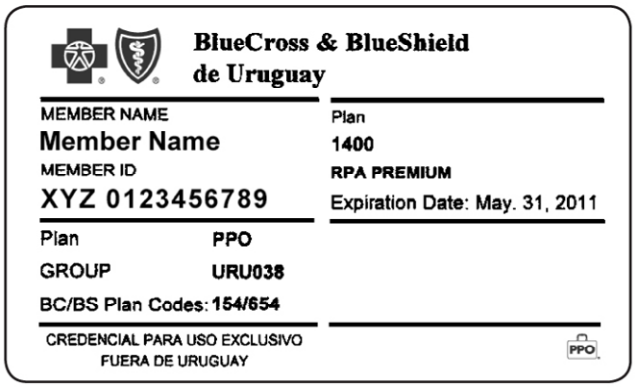
Some Blue ID cards don't have any suitcase logo on them. The ID cards for Medicaid, State Children's Health Insurance Programs (SCHIP) if administered as part of State's Medicaid, and Medicare Complementary and Supplemental products, also known as Medigap. Government-determined reimbursement levels apply to these products. While BCBSOK routes all of these claims for out-of-area members to the member's Blue Plan, most of the Medicare Complementary or Medigap claims are sent directly from the Medicare intermediary to the member's Plan via the established electronic crossover process.

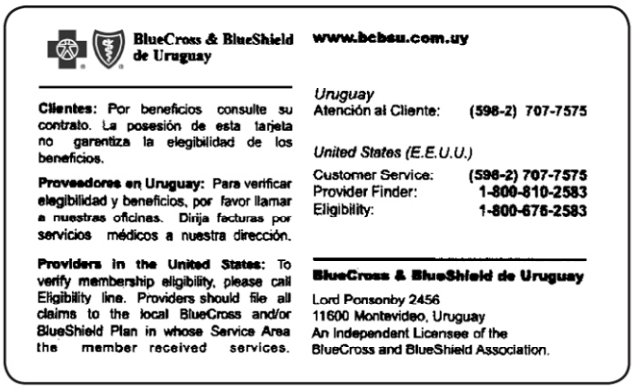
Tip: While BCBSOK *routes all of these claims for out-of-area members to the member's Blue Plan, most of the Medicare Complementary or Medigap claims are sent directly from the Medicare intermediary to the member's Blue Plan via the established electronic Medicare crossover process.*

3.3 How to Identify International Members

Occasionally, you may see identification cards from members of International Licensees. Currently those Licensees include Blue Cross Blue Shield of the U.S. Virgin Islands, BlueCross & BlueShield of Uruguay, Blue Cross and Blue Shield of Panama, Blue Cross Blue Shield of Costa Rica and GeoBlue, but if in doubt, always check with BCBSOK as the list of International Licensees may change. ID cards from these Licensees will also contain three-character alpha prefixes and may or may not have one of the benefit product logos referenced in the following sections. Please treat these members the same as you would domestic Blue Plan members (e.g., do not collect any payment from the member beyond cost-sharing amounts such as deductible, coinsurance and co-payment) and file their claims to BCBSOK.

Example of an ID card from an International Licensee:





Canadian ID Cards

Please note: The Canadian Association of Blue Cross Plans and its member plans are separate and distinct from the Blue Cross and Blue Shield Association (BCBSA) and its member Plans in the United States.

You may occasionally see ID cards for people who are covered by a Canadian Blue Cross plan. Claims for Canadian Blue Cross plan members are not processed through the BlueCard® Program.

Please follow the instructions of the Blue Cross plans in Canada and those, if any, on the ID cards for servicing their members. The Blue Cross plans in Canada are:

Alberta Blue Cross	Ontario Blue Cross	Quebec Blue Cross
Manitoba Blue Cross	Pacific Blue Cross	Saskatchewan Blue Cross
Medavie Blue Cross		

*Source: http://www.bluecross.ca/en/contact.html

3.4 Consumer Directed Healthcare and Healthcare Debit Cards

Consumer Directed Healthcare (CDHC) is a term that refers to a movement in the healthcare industry to empower Members, reduce employer costs and change consumer healthcare purchasing behavior.

Health plans that offer CDHC provide the member with additional information to make an informed and appropriate healthcare decision through the use of member support tools, provider and network information and financial incentives.

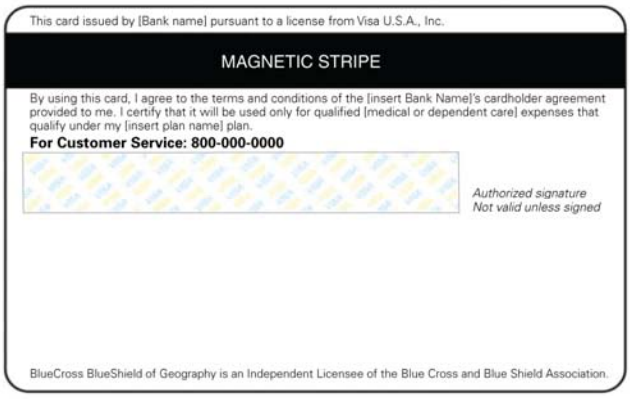
Members who have Consumer-Directed Healthcare (CDHC) plans often have healthcare debit cards that allow them to pay for out-of-pocket costs using funds from their Health Reimbursement Arrangement (HRA), Health Savings Account (HSA) or Flexible Spending Account (FSA). All three are types of tax favored accounts offered by the member's employer to pay for eligible expenses not covered by the health plan.

Some cards are "stand-alone" debit cards that cover eligible out-of-pocket costs, while others also serve as a health plan member ID card. These debit cards can help you simplify your administration process and can potentially help:

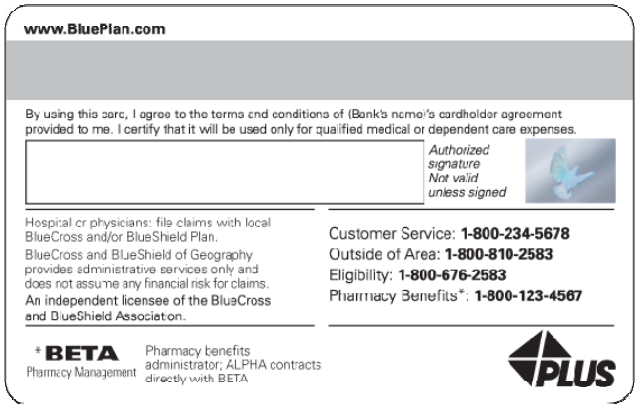
1. Reduce bad debt
2. Reduce paperwork for billing statements
3. Minimize bookkeeping and patient account functions for handling cash and checks
4. Avoid unnecessary claim payment delays

In some cases, the card will display the Blue Cross and Blue Shield trademarks, along with the logo from a major debit card such as MasterCard® or Visa®.

Below is a sample stand-alone healthcare debit card:



Below is a sample combined healthcare debit card and member ID card:



The cards include a magnetic strip allowing providers to swipe the card to collect the member's cost-sharing amount (i.e., copayment). With healthcare debit cards, members can pay for copayments and other out-of-pocket expenses by swiping the card though any debit card swipe terminal. The funds will be deducted automatically from the member's appropriate HRA, HSA or FSA account.

Helpful Tips:

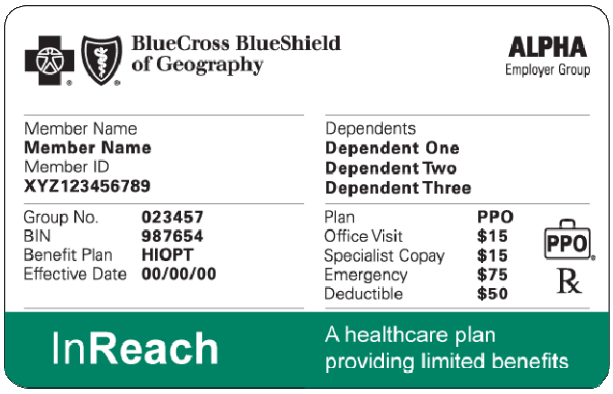
- *Using the member's current member ID number, including alpha prefix, carefully determine the member's financial responsibility before processing payment. Check eligibility and benefits electronically through **BCBSOK** or by calling 1.800.676.BLUE (2583).*
- *All services, regardless of whether or not you've collected the member responsibility at the time of service, must be billed to **BCBSOK** for proper benefit determination, and to update the member's claim history.*
- *Please do not use the card to process full payment up front. If you have any questions about the member's benefits, please contact 1.800.676.BLUE (2583) or, for questions about the healthcare debit card processing instructions or payment issues, please contact the toll-free debit card administrator's number on the back of the card.*

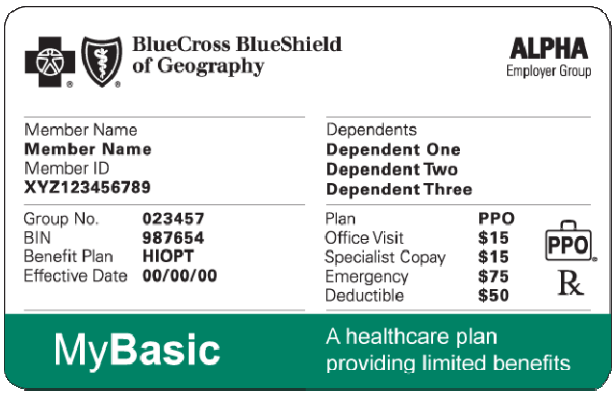
3.5 Limited Benefits Products

Currently BCBSOK doesn't offer such limited benefit plans to our members, however you may see patients with limited benefits who are covered by another Blue Plan.

Verifying Blue patients' benefits and eligibility is important, now more than ever. Since new products and benefit types entered the market.

These ID cards may look like this:





How to find out if the patient has limited benefit coverage?

In addition to obtaining a copy of the patient's ID card and regardless of the benefit product type, we recommend that you verify patient's benefits and eligibility.

You may do so electronically by submitting HIPAA 270 eligibility inquiry to BCBSOK at www.bcbsok.com or via an Electronic Data Interchange (EDI) transaction or may call 1.800.676.BLUE (2583) eligibility line for out-of-area members.

Both electronically and via phone, you will receive patient's accumulated benefits to help you understand the remaining benefits left for the member.

- *Tips: In addition to obtaining a copy of the member's ID card, regardless of the benefit product type, always verify eligibility and benefits electronically with **Blue Cross and Blue Shield of Oklahoma (BCBSOK)** or by calling 1-800-676-BLUE (2583). You will receive the member's accumulated benefits to help you understand his/her remaining benefits.*

- *If the cost of service extends beyond the member's benefit coverage limit, please inform your patient of any additional liability he/she might have.*
- *If you have questions regarding a Blue Plan's limited benefits ID card/product, please contact* ***BCBSOK.***

If the cost of services extends beyond the patient's benefit coverage limit, inform the patient of any additional liability they might have.

What should I do if the patient's benefits are exhausted before the end of their treatment?

Annual benefit limits should be handled in the same manner as any other limits on the medical coverage. Any services beyond the covered amounts or the number of treatment are member's liability.

We recommend that you inform the patient of any potential liability they might have as soon as possible.

Who do I contact if I have additional questions about Limited Benefit Plans?

If you have any questions regarding BCBSOK or any other Blue Plans' Limited Benefits products, contact BCBSOK at *1-800-676-BLUE (2583).*

3.5.1 Reference Based Benefits

With health care costs increasing, employers are considering alternative approaches to control health care expenses by placing a greater emphasis on employee accountability by encouraging members to take a more active role while making health care decisions. Plans have begun to introduce Reference Based Benefits, which limit certain (or specific) benefits to a dollar amount that incents members to actively shop for health care for those services.

The goal of Reference Based Benefits is to have members engage in their health choices by giving them an incentive to shop for cost effective providers and facilities. Reference Based Benefit designs hold the member responsible for any expenses above a calculated "reference cost" ceiling for a single episode of service. Due to the possibility of increased member cost sharing, Reference Based Benefits will incent members to use Plan transparency tools, like the National Consumer Cost Tool (NCCT), to search for and identify services that can be performed at cost effective providers and/or facilities that charge at or below the reference cost ceiling.

How does Reference Based Benefits work?

Reference Based Benefits are a new benefit feature where the Plan will pay up to a pre-determined amount for specific procedures called a "Reference Cost." If the allowed amount exceeds the reference cost, that excess amount becomes the members' responsibility.

How are Reference Costs Established?

The reference costs are established for an episode of care based on claims data received by BCBSOK from providers in your area.

How will I get paid?

Reference Based Benefits will not modify the current contracting amount agreed on between you and BCBSOK. Providers can expect to receive their contract rate on all procedures where Reference Based Benefits apply.

Example 1: If a member has a reference cost of $500 for an MRI of the spine and the allowable amount is $700, then BCBSOK will pay up to the $500 for the procedure and the member is responsible for the $200.

Example 2: If a member has a reference cost ceiling of $600 for a CT scan of the Head/Brain and allowable amount is $400, then BCBSOK will pay up to the $400 for the procedure.

How much will the member be responsible for out-of-pocket?

When Reference Based Benefits are applied and the cost of the services rendered is less than the reference cost ceiling, then BCBSOK will pay eligible benefits as it has in the past; while the member continues to pay their standard cost sharing amounts in the forms of: co-insurance, co-pay, or deductible as normal.

If the cost of the services rendered exceeds the reference cost ceiling, then BCBSOK will pay benefits up to that reference cost ceiling, while the member continues to pay their standard cost sharing amounts in the forms of: co-insurance, co-pay, or deductible; as well as any amount above the reference cost ceiling up to the contractual amount.

How will I be able to identify if a member is covered under Reference Based Benefits?

When you receive a response from a benefits and eligibility inquiry, you will be notified if a member is covered under Reference Based Benefits.

Additionally, you can call the Blue Eligibility number (800-676-2583) to verify if a member is covered under Reference Based Benefits.

Do I need to do anything different if a member is covered under Reference Based Benefits?

While there are no additional steps that you need to take, you may want to verify the reference cost maximum prior to performing a procedure covered under Reference Based Benefits. You can check if Reference Based Benefits apply to professional and facility charges for the member, by submitting an electronic a benefits and eligibility inquiry to your local Blue Plan. Alternatively, you can contact the member's Plan by calling the Blue Eligibility number (800-676-2583).

Do Reference Based Benefits apply to emergency services?

No. Reference Based Benefits are not applicable to any service that is urgent or emergent.

Do Reference Based Benefits apply to benefits under the Affordable Care Act essential health benefits?

Yes. Health plans must offer products at the same actuarial value to comply with the Affordable Care Act legislative rules.

How does the member identify services at or below the reference cost?

Members with Reference-Based Benefits use consumer transparency tools to determine if a provider will deliver the service for less than the reference cost.

How will the Reference Based Benefits cost apply to professional and facility charges?

For more information on how Reference Based Benefits will apply costs to the professional and facility charges please submit an electronic benefits and eligibility inquiry to the members local Blue Plan. If you have additional questions, you can contact the Blue Eligibility number (800-676-2583) for the member you are seeing. *For Electronic Provider Access, see section 3.8.*

What if a member covered under Reference Based Benefits asks for additional information about their benefits?

Since members are subject to any charges above the reference cost up to the contractual amount for particular services, members may ask you to estimate how much a service will cost.

Also, you can direct members to view their Blue Plans transparency tools to learn more about the cost established for an episode of care.

What procedures are covered under Reference Based Benefits?

The following procedures will be covered under Reference Based Benefits:

* Applicable services may vary by employer group.

Where do I submit the claim?

You should submit the claim to Blue Cross and Blue Shield of Oklahoma (BCBSOK) under your current billing practices.

How will Reference Based Benefits be shown on a payment remittance?

When you receive payment for services the claim will pay per the member's benefits with any amount over the reference cost being applied to the Benefit Maximum.

Is there anything different that I need to submit with member claims?

No. You should continue to submit your claims as you previously have to BCBSOK.

Who do I contact if I have a question?

If you have any questions regarding the Reference Based Benefits, please contact BCBSOK at 800-496-5774.

3.6 Coverage and Eligibility Verification

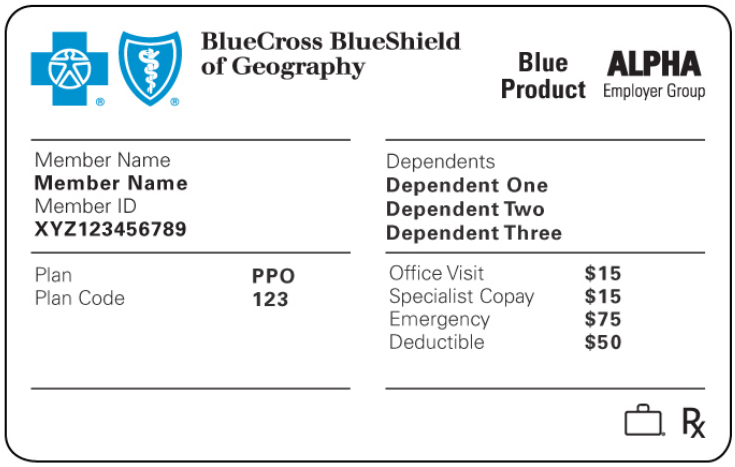
For BCBSOK members, contact 800-496-5774.

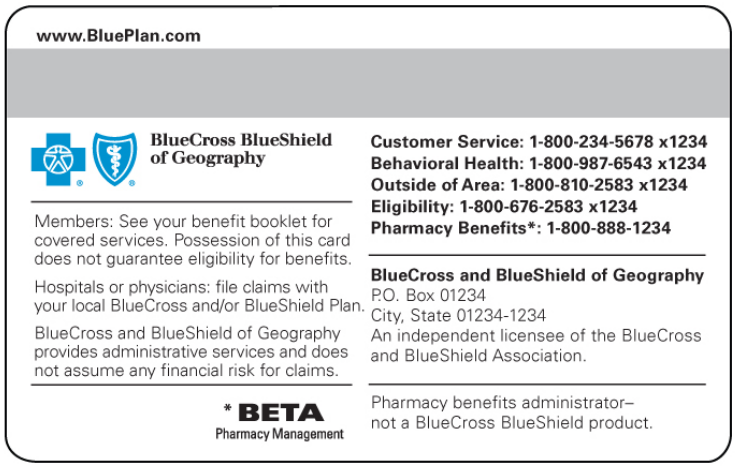
For other Blue Plans' members, submit an electronic inquiry to BCBSOK or call BlueCard Eligibility 1.800.676.BLUE (2583) to verify the patient's eligibility and coverage:

- Electronic—Submit a HIPAA 270 transaction (eligibility) to BCBSOK.

  You can receive real-time responses to your eligibility requests for out-of-area members between 6:00 a.m. and Midnight, Central Time, Monday through Saturday.
- Phone—Call BlueCard Eligibility 1.800.676.BLUE (2583)
  - English and Spanish speaking phone operators are available to assist you.
  - Blue Plans are located throughout the country and may operate on a different time schedule than BCBSOK. You may be transferred to a voice response system linked to customer enrollment and benefits outside that Plan's regular business hours.
  - The BlueCard Eligibility line is for eligibility, benefit and pre-certification/referral authorization inquiries only. It should not be used for claim status. *See the Claim Filing section for claim filing information.*
- Electronic Health ID Cards
  - Some local BCBS Plans have implemented electronic health ID cards to facilitate a seamless coverage and eligibility verification process.
  - Electronic health ID cards enable electronic transfer of core subscriber/member data from the ID card to the provider's system.
  - A Blue electronic health ID card has a magnetic stripe on the back of the ID card, similar to what you can find on the back of a credit or debit card. The subscriber/member electronic data is embedded on the third track of the three-track magnetic stripe.

- Core subscriber/member data elements embedded on the third track of the magnetic stripe include: subscriber/member name, subscriber/member ID, subscriber/member date of birth and PlanID.
- The PlanID data element identifies the health plan that issued the ID card. PlanID will help providers facilitate health transactions among various payers in the market place.
- Providers will need a *track 3 card reader* in order for the data on track 3 of the magnetic stripe to be read (the majority of card readers in provider offices only read tracks 1 & 2 of the magnetic stripe; tracks 1 & 2 are proprietary to the financial industry).
- Sample of electronic health ID card:





3.7 Utilization Review

You should remind patients that they are responsible for obtaining pre-certification/preauthorization for out-patient services from their Blue Plan. Participating providers are responsible for obtaining pre-service review for inpatient facility services when the services are required by the account or member contract (Provider Financial Responsibility, see section 3.9). In addition, members are held harmless when pre-service review is required and not received for inpatient facility services (unless an account receives an approved exception).

Providers must also follow specified timeframes for pre-service review notifications:

1. 48 hours to notify the member's Plan of change in pre-service review; and
2. 72 hours for emergency/urgent pre-service review notification.

General information on pre-certification/preauthorization information can be found on the Out-of-Area member Medical Policy and Pre-Authorization/Pre-Certification Router at http://www.bcbsok.com/provider/standards/mppc.html utilizing the three letter prefix found on the member ID card.

You may also contact the member's Plan on the member's behalf. You can do so by:

- For BCBSOK members, contact 800-672-2378.
- For other Blue Plans members:
  - Call BlueCard Eligibility 1.800.676.BLUE (2583)—ask to be transferred to the utilization review area.
    - When pre-certification/preauthorization for a specific member is handled separately from eligibility verifications at the member's Blue Plan, your call will be routed directly to the area that handles pre-certification/pre-authorization. You will choose from four options depending on the type of service for which you are calling:
      - Medical/Surgical
      - Behavioral Health
      - Diagnostic Imaging/Radiology
      - Durable/Home Medical Equipment (D/HME)

      If you are inquiring about both, eligibility and pre-certification/pre-authorization, through 1-800-676-BLUE(2583), your eligibility inquiry will be addressed first. Then you will be transferred, as appropriate, to the pre-certification/preauthorization area.
  - Submit an electronic HIPAA 278 transaction (referral/authorization) to BCBSOK.
  - The member's Blue Plan may contact you directly regarding clinical information and medical records prior to treatment or for concurrent review or disease management for a specific member.

When obtaining pre-certification/preauthorization, please provide as much information as possible, to minimize potential claims issues. Providers are encouraged to follow-up immediately with a member's Blue Plan to communicate any changes in treatment or setting to ensure existing

authorization is modified or a new one is obtained, if needed. Failure to obtain approval for the additional days may result in claims processing delays and potential payment denials.

3.8 Electronic Provider Access

On January 1, 2014, the Blue Cross and Blue Shield Plans launched a new tool that gives providers the ability to access out-of-area member's Blue Plan (Home Plan) provider portals to conduct electronic pre-service review. The term pre-service review is used to refer to pre-notification, pre-certification, pre-authorization and prior approval, amongst other pre-claim processes. Electronic Provider Access (EPA) enables providers to use their local Blue Plan provider portal to gain access to an out-of-area member's Home Plan provider portal, through a secure routing mechanism. Once in the Home Plan provider portal, the out-of-area provider has the same access to electronic pre-service review capabilities as the Home Plan's local providers.

The availability of EPA varies depending on the capabilities of each Home Plan. Some Home Plans have electronic pre-service review for many services, while others do not. The following describes how to use EPA and what to expect when attempting to contact Home Plans.

Using the EPA Tool

The first step for providers is to go to www.bcbsok.com/providers and log-in. You then select the menu option: "**Pre-Service Review for Out-of-Area Members (includes notification, pre-certification, pre-authorization and prior approval).**

Next, you will be asked to enter the alpha prefix from the member's ID card. The alpha prefix is the first three alpha characters that precede the member id.

Note: You can first check whether pre-certification is required by the Home Plan by either:

1. Sending a service-specific request through BlueExchange.
2. Accessing the Home Plan's pre-certification requirements pages by using the medical policy router.

Entering the member's alpha prefix from the ID card automatically routes you to the Home Plan EPA landing page. This page welcomes you to the Home Plan portal and indicates that you have left BCBSOK portal. The landing page allows you to connect to the available electronic pre-service review processes. Because the screens and functionality of Home Plan pre-service review processes vary widely, Home Plans may include instructional documents or e-learning tools on the Home Plan landing page to provide instruction on how to conduct an electronic pre-service review. The page also includes instructions for conducting pre-service review for services where the electronic function is not available.

The Home Plan landing page looks similar across Home Plans, but will be customized to the particular Home Plan based on the electronic pre-service review services they offer.

3.9 Provider Financial Responsibility for Pre-Service Review for BlueCard® Members

As of July 1, 2014, BCBSOK participating providers became responsible for obtaining pre-service review for inpatient facility services for BlueCard® members and holding the member harmless when pre-service review is required by the account or member contract and not received for inpatient services. Participating providers must also:

- Notify the member's Blue Plan within 48 hours when a change or modifications to the original pre-service review occurs.
- Obtain pre-service review for emergency and/or urgent admissions within 72 hours.

Failure to contact the member's Blue Plan for pre-service review or for a change or modification of the pre-service review will result in non-payment for inpatient facility services. The BlueCard® member must be held harmless and cannot be balance-billed if pre-service review has not occurred*.

Pre-service review contact information for a member's Blue Plan is provided on the member's identification card. Pre-service review requirements can also be determined by:

- Using the Electronic Provider Access (EPA) tool available at BCBSOK provider portal at www.bcbsok.com/providers. Note: the availability of EPA will vary depending on the capabilities of each member's Blue Plan
- Submitting an ANSI 278 electronic transaction to BCBSOK or calling 1.800.676.BLUE.

Services that deny as not medically necessary remain member liability

Who do I contact if I have additional questions about Provider Financial Responsibility for Pre-Service Review?

If you have any questions on Provider Financial Responsibility or general questions, please call BCBSOK at 1-800-722-3730.

Who do I contact if I have additional questions about Electronic Provider Access?

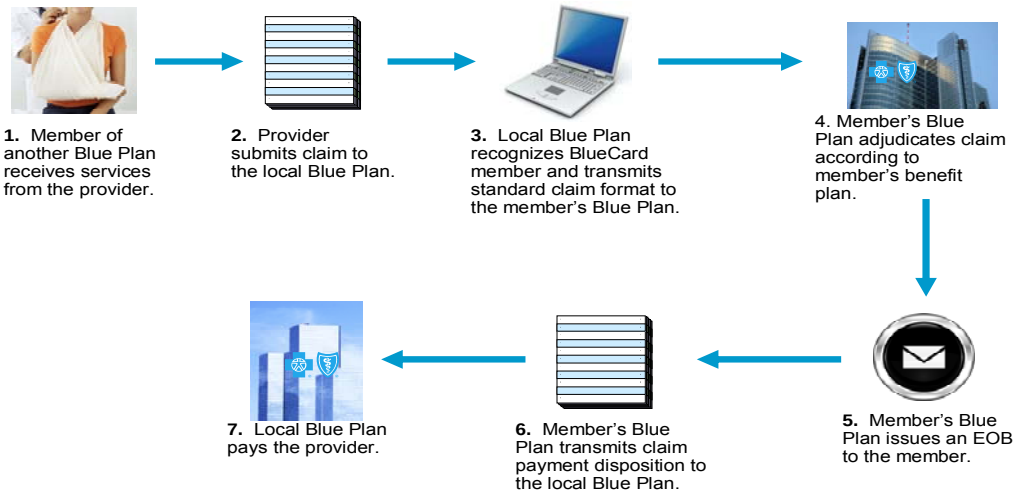
If you have any questions on how to use the EPA tool, please call BCBSOK at 1-800-722-3730.

** Unless the member signed a written consent to be billed prior to rendering the service.*

4. Claim Filing

4.1 How Claims Flow through BlueCard

Below is an example of how claims flow through BlueCard



After the member of another Blue Plan receives services from you, you should file the claim with BCBSOK. We will work with the member's Plan to process the claim and the member's Plan will send an explanation of benefit or EOB to the member. We will send you an explanation of payment or the remittance advice and issue the payment to you under the terms of our contract with you and based on the members benefits and coverage.

You should always submit claims to BCBSOK, PO BOX 3283, Tulsa, OK 74102-3283.

Following these helpful tips will improve your claim experience:

- Ask members for their current member ID card and regularly obtain new photocopies of it (front and back). Having the current card enables you to submit claims with the appropriate member information (including alpha prefix) and avoid unnecessary claims payment delays.
- Check eligibility and benefits electronically or by calling 1.800.676.BLUE (2583). Be sure to provide the member's alpha prefix.
- Verify the member's cost sharing amount before processing payment. Please do not process full payment upfront. Contracted providers may only collect copayments and deductibles up front or amounts for noncovered services. Coinsurance amounts may not be collected until the claim is processed and the provider is notified.
- Indicate any payment you collected from the patient on the claim. (On the 837 electronic claim submission form, check field AMT01=**F5** patient paid amount; on the CMS1500 locator **29** amount paid; on UB92 locator **54** prior payment; on UB04 locator **53** prior payment.)

- Submit all Blue claims to BCBSOK, PO BOX 3283 Tulsa, OK 74102-3283. Be sure to include the member's complete identification number when you submit the claim. This includes the three-character alpha prefix. Submit claims with only valid alpha-prefixes; claims with incorrect or missing alpha prefixes and member identification numbers cannot be processed.
- In cases where there is more than one payer and a Blue Plan is a primary payer, submit Other Party Liability (OPL) information with the Blue claim. Upon receipt, BCBSOK will electronically route the claim to the member's Blue Plan. The member's Plan then processes the claim and approves payment; BCBSOK will reimburse you for services.
- Do not send duplicate claims. Sending another claim, or having your billing agency resubmit claims automatically, actually slows down the claims payment process and creates confusion for the member.
- Check claims status by contacting BCBSOK at 800-496-5774 or submitting an electronic HIPAA 276 transaction (claim status request) to BCBSOK.

4.2 Medicare Advantage Claims

4.2.1 Medicare Advantage Overview

"Medicare Advantage" (MA) is the program alternative to standard Medicare Part A and Part B fee-for-service coverage; generally referred to as "traditional Medicare".

MA offers Medicare beneficiaries several product options (similar to those available in the commercial market), including health maintenance organization (HMO), preferred provider organization (PPO), point-of-service (POS) and private fee-for-service (PFFS) plans.

All Medicare Advantage plans must offer beneficiaries at least the standard Medicare Part A and B benefits, but many offer additional covered services as well (e.g., enhanced vision and dental benefits).

In addition to these products, Medicare Advantage organizations may also offer a Special Needs Plan (SNP), which can limit enrollment to subgroups of the Medicare population in order to focus on ensuring that their special needs are met as effectively as possible.

Medicare Advantage plans may allow in- and out-of-network benefits, depending on the type of product selected. Providers should confirm the level of coverage — by calling 1.800.676.BLUE (2583) or submitting an electronic inquiry — for all Medicare Advantage members prior to providing service since the level of benefits, and coverage rules, may vary depending on the Medicare Advantage plan.

Types of Medicare Advantage Plans

Medicare Advantage HMO

A Medicare Advantage HMO is a Medicare managed care option in which members typically receive a set of predetermined and prepaid services provided by a network of physicians and hospitals. Generally (except in urgent or emergency care situations), medical services are only covered when provided by in-network providers. The level of benefits, and the coverage rules, may vary by Medicare Advantage plan.

Medicare Advantage POS

A Medicare Advantage POS program is an option available through some Medicare HMO programs. It allows members to determine — at the point of service — whether they want to receive certain designated services within the HMO system, or seek such services outside the HMO's provider network (usually at greater cost to the member). The Medicare Advantage POS plan may specify which services will be available outside of the HMO's provider network.

Medicare Advantage PPO

A Medicare Advantage PPO is a plan that has a network of providers, but unlike traditional HMO products, it allows members who enroll access to services provided outside the contracted network of providers. Required member cost-sharing may be greater when covered services are obtained out-of-network. Medicare Advantage PPO plans may be offered on a local or regional (frequently multi-state) basis. Special payment and other rules apply to regional PPOs.

Blue Medicare Advantage PPO members have in-network access to Blue MA PPO providers.

Medicare Advantage PFFS

A Medicare Advantage PFFS plan is a plan in which the member may go to any Medicare-approved doctor or hospital that accepts the plan's terms and conditions of participation. Acceptance is "deemed" to occur where the provider is aware, in advance of furnishing services, that the member is enrolled in a PFFS product and where the provider has reasonable access to the terms and conditions of participation.

The Medicare Advantage Organization, rather than the Medicare program, pays for services rendered to such members. Members are responsible for cost-sharing, as specified in the plan, and balance billing may be permitted in limited instance where the provider is a network provider and the plan expressly allows for balance billing.

Medicare Advantage PFFS varies from the other Blue products you might currently participate in:

- You can see and treat any Medicare Advantage PFFS member without having a contract with BCBSOK.
- If you do provide services, you will do so under the Terms and Conditions of that member's Blue Plan.
- MA PFFS Terms and Conditions might vary for each Blue Plan and we advise that you review them before servicing MA PFFS members.
- Please refer to the back of the member's ID card for information on accessing the Plan's Terms and Conditions. You may choose to render services to a MA PFFS member on an episode of care (claim-by-claim) basis.

- For your convenience, you will find MA PFFS Terms and Conditions for all Blue Plans at: www.bcbsok.com/providers by providing the member's three-letter alpha prefix
- Submit your MA PFFS claims to BCBSOK.

Medicare Advantage Medical Savings Account (MSA)

Medicare Advantage Medical Savings Account (MSA) is a Medicare health plan option made up of two parts. One part is a Medicare MSA Health Insurance Policy with a high deductible. The other part is a special savings account where Medicare deposits money to help members pay their medical bills.

4.2.2 Medicare Advantage PPO Network Sharing

What is BCBS Medicare Advantage PPO Network Sharing?

All Blue Medicare Advantage PPO Plans participate in reciprocal network sharing. This network sharing allows all Blue MA PPO members to obtain in-network benefits when traveling or living in the service area of any other Blue MA PPO Plan as long as
the member sees a contracted MA PPO provider.

What does the BCBS Medicare Advantage (MA) PPO Network Sharing mean to me?

If you are a contracted MA PPO provider with BCBSOK and you see MA PPO members from other Blue Plans, these members will be extended the same contractual access to care and will be reimbursed in accordance with your negotiated rate with your BCBSOK contract. These members will receive in-network benefits in accordance with their member contract.

If you are not a contracted MA PPO provider with BCBSOK and you provide services for any Blue Medicare Advantage members, you will receive the Medicare allowed amount for covered services. For urgent or emergency care, you will be reimbursed at the member's in-network benefit level. Other services will be reimbursed at the out-of-network benefit level.

How do I recognize an out-of-area member from one of these Plans participating in the BCBS MA PPO network sharing?

You can recognize a MA PPO member when their Blue Cross Blue Shield member ID card has the following logo.

The *"MA"* in the suitcase indicates a member who is covered under the MA PPO network sharing program. Members have been asked not to show their standard Medicare ID card when receiving services; instead, members should provide their Blue Cross and/or Blue Shield member ID.

Do I have to provide services to Medicare Advantage PPO members from other Blue Plans?

If you are a contracted Medicare Advantage PPO provider with BCBSOK, you must provide the same access to care as you do for BCBSOK Blue MA PPO members. You can expect to receive the same contracted rates for such services.

If you are not a Medicare Advantage PPO contracted provider, you may see Medicare Advantage members from other Blue Plans but you are not required to do so. Should you decide to provide services to Blue Medicare Advantage members, you will be reimbursed for covered services at the Medicare allowed amount based on where the services were rendered and under the member's out-of-network benefits. For urgent or emergency care, you will be reimbursed at the in-network benefit level.

What if my practice is closed to new local Blue Medicare Advantage PPO members?

If your practice is closed to new local Blue MA PPO members, you do not have to provide care for Blue MA PPO out-of-area members. The same contractual arrangements apply to these out-of-area network sharing members as your local MA PPO members.

How do I verify benefits and eligibility?

Call BlueCard Eligibility Line at 1.800.676.BLUE (2583) and provide the member's three-digit alpha prefix located on the ID card.

You may also submit electronic eligibility requests for Blue members, follow these three easy steps:

- Log in to www.bcbsok.com/providers/
- Follow the link to verify member eligibility
- Submit your request

If you experience difficulty obtaining eligibility information, please record the alpha prefix and report it to BCBSOK. *See section 3.8, Electronic Provider Access.*

Where do I submit the claim?

You should submit the claim to BCBSOK under your current billing practices. Do not bill Medicare directly for any services rendered to a Medicare Advantage member.

What will I be paid for providing services to these out-of-area Medicare Advantage PPO network sharing members?

If you are a MA PPO contracted provider with BCBSOK, benefits will be based on your contracted MA PPO rate for providing covered services to MA PPO members from any MA PPO Plan. Once you submit the MA claim, BCBSOK will work with the other Plan to determine benefits and send you the payment.

What will I be paid for providing services to Medicare Advantage out-of-area members not participating in the Medicare Advantage PPO Network Sharing?

When you provide covered services to other Blue Medicare Advantage out-of-area members' benefits will be based on the Medicare allowed amount. Once you submit the MA claim, BCBSOK will send you the payment. However, these services will be paid under the member's out-of-network benefits unless for urgent or emergency care.

What is the member cost sharing level and co-payments?

A MA PPO member cost sharing level and co-payment is based on the member's health plan. You may collect the co-payment amounts from the member at the time of service. To determine the cost sharing and/or co-payment amounts, you should call the Eligibility Line at 1.800.676.BLUE (2583).

May I balance bill the member the difference in my charge and the allowance?

No, you may not balance bill the member for this difference. Members may be billed for any deductibles, co-insurance, and/or co-pays.

What if I disagree with the reimbursement amount I received?

If there is a question concerning the reimbursement amount, contact your local Plan at the customer service number on the back of your ID card.

Who do I contact if I have a question about MA PPO network sharing?

If you have any questions regarding the MA program or products, contact BCBSOK at the customer service number on the back of your ID card.

What is BCBS Medicare Advantage PPO Network Sharing?

Network sharing allows MA PPO members from MA PPO Blue Plans to obtain in-network benefits when traveling or living in the service areas of the MA PPO Plans as long as the member sees a contracted Medicare Advantage PPO provider. Medicare Advantage PPO shared networks are available in 35 states and one territory:

Alabama	Arkansas	California	Colorado
Connecticut	Florida	Georgia	Hawaii
Idaho	Illinois*	Indiana	Kentucky
Maine	Massachusetts	Michigan	Missouri
Montana	North Carolina	Nevada	New Hampshire
New Jersey	New Mexico	New York	Ohio
Oklahoma	Oregon	Pennsylvania	Puerto Rico
South Carolina	Tennessee	Texas	Utah
Virginia	Washington	Wisconsin	West Virginia

**participating effective January 1, 2015*

What does the BCBS Medicare Advantage PPO Network Sharing mean to me?

There is no change from your current practice. You should continue to verify eligibility and bill for services as you currently do for any out-of-area Blue Medicare Advantage member you agree to treat. Benefits will be based on the Medicare allowed amount for covered services and be paid under the member's out-of-network benefits unless for urgent or emergency care. Once you submit the MA claim, BCBSOK will send you the payment.

How do I recognize an out-of-area member from one of these Plans?

The *"MA"* in the suitcase on the member's ID card indicates a member who is covered under the network sharing program.

Members have been asked not to show their standard Medicare ID card when receiving services; instead, members should provide their Blue Cross and/or Blue Shield member ID.

Do I have to provide services to these Medicare Advantage PPO network sharing members or other Blue MA members from out-of-area?

You may see any out-of-area Blue Medicare Advantage members but you are not required to provide services. Should you decide to provide services to any Blue Medicare Advantage out-of-area members, you will be reimbursed for covered services at the Medicare allowed amount based on where the services were rendered and under the member's out-of-network benefits. For urgent or emergency care, you will be reimbursed at the in-network benefit level.

If I chose to provide services, how do I verify benefits and eligibility?

Call BlueCard *Eligibility* at 1.800.676.BLUE (2583) and provide the member's alpha prefix located on the ID card.

You may also submit electronic eligibility requests for Blue members, follow these three easy steps:

- Log in to www.bcbsok.com/providers
- Follow the link to verify member eligibility
- Submit your request

If you experience difficulty obtaining eligibility information, please record the alpha prefix and report it to BCBSOK.

Where do I submit the claim?

You should submit the claim to BCBSOK under your current billing practices. Do not bill Medicare directly for any services rendered to a Medicare Advantage member.

What can I expect for reimbursement?

Benefits will be based on the Medicare allowed amount for providing covered services to any Blue Medicare Advantage out-of-area members. Once you submit the MA claim, BCBSOK will send you the payment. These services will be paid under the members out-of-network benefits unless services were for urgent or emergency care.

What is the member cost sharing level and co-payments?

Any Blue MA members from out-of-area will pay their out-of-network cost sharing amount based on their health plan. You may collect the co-payment amounts from the member at the time of service.

May I request payment upfront?

Generally, once the member receives care, you should not ask for full payment up front other than out-of-pocket expenses (deductible, co-payment, coinsurance, and non-covered services).

Under certain circumstances when the member has been notified in advance that a service will not be covered, you may request payment from the member before services are rendered or billed to the member. The member should sign an Advance Benefit Notification (ABN) form before services are rendered in these situations.

May I balance bill the member the difference in my charge and the allowance?

No, you may not balance bill the member for this difference. Members may be billed for any deductibles, co-insurance, and/or co-pays.

What if I disagree with the reimbursement amount I received?

If there is a question concerning the reimbursement amount, contact your local Plan at BCBSOK.

Who do I contact if I have a question about MA PPO network sharing?

If you have any questions regarding the MA program or products, contact BCBSOK at the customer service number on the back of your member ID card.

4.2.3 Eligibility Verification

- Verify eligibility by contacting 1.800.676.BLUE (2583) and providing an alpha prefix or by submitting an electronic inquiry to your local Plan and providing the alpha prefix.
- Be sure to ask if Medicare Advantage benefits apply.
- If you experience difficulty obtaining eligibility information, please record the alpha prefix and report it to BCBSOK.

4.2.4 Medicare Advantage Claims Submission

- Submit all Medicare Advantage claims to BCBSOK.
- Do not bill Medicare directly for any services rendered to a Medicare Advantage member.
- Payment will be made directly by a Blue Plan.

4.2.5 Reimbursement for Medicare Advantage PPO, HMO, POS, PFFS

Note To Provider: The reimbursement information below applies when a provider treats a Blue Medicare Advantage member to whom the provider's contract does not apply.

Examples:

- A provider that is contracted for Medicare Advantage PPO business treats a Medicare Advantage HMO member.
- A provider that is contracted for commercial business only treats a MA PPO member.
- A provider that is contracted for Medicare Advantage HMO business treats any MA PPO member.
- A provider that is contracted for local Medicare Advantage HMO business treats an out-of-area MA HMO member.
- A provider that is not contracted with the local Plan treats a MA HMO member.

Based upon the Centers for Medicare and Medicaid Services (CMS) regulations, if you are a provider who accepts Medicare assignment and you render services to a Medicare Advantage member for whom you have no obligation to provide services under your contract with a Blue Plan, you will generally be considered a non-contracted provider and be reimbursed the equivalent of the

current Medicare allowed amount for all covered services (i.e., the amount you would collect if the beneficiary were enrolled in traditional Medicare).

Special payment rules apply to hospitals and certain other entities (e.g., skilled nursing facilities) that are non-contracted providers.

Providers should make sure they understand the applicable Medicare Advantage reimbursement rules.

Providers that are paid on a reasonable cost basis under Original Medicare should send their CMS Interim Payment Rate letter with their Medicare Advantage claim. This letter will be needed by the Plan to calculate the Medicare Allowed amount.

Other than the applicable member cost sharing amounts, reimbursement is made directly by a Blue Plan or its branded affiliate. In general, you may collect only the applicable cost sharing (e.g., co-payment) amounts from the member at the time of service, and may not otherwise charge or balance bill the member.

NOTE: Enrollee payment responsibilities can include more than copayments (e.g., deductibles).

Please review the remittance notice concerning Medicare Advantage plan payment, member's payment responsibility, and balance billing limitations.

Medicare Advantage Private-Fee-For-Service (PFFS) Claim Reimbursement

If you have rendered services for a Blue out-of-area Medicare Advantage PFFS member, but are not obligated to provide services to such member under a contract with a Blue Plan, you will generally be reimbursed the Medicare allowed amount for all covered services (i.e., the amount you would collect if the beneficiary were enrolled in traditional Medicare). Providers should make sure they understand the applicable Medicare Advantage reimbursement rules by reviewing the Terms & Conditions under the member's Blue Plan. You can find the MA PFFS Terms & Conditions using the web locator at bcbsok.com. Simply enter the member's three-letter alpha prefix.

Other than the applicable member cost sharing amounts, reimbursement is made directly by a Blue Plan. In general, you may collect only the applicable cost sharing (e.g., co-payment) amounts from the member at the time of service, and may not otherwise charge or balance bill the member.

Please review the remittance notice concerning Medicare Advantage plan payment, member's payment responsibility and balance billing limitations.

NOTE TO PROVIDER: The reimbursement information below applies when a provider treats a Blue Medicare Advantage member to whom the provider's contract applies.

Examples:

- A provider that is contracted for Medicare Advantage PPO business treats an out-of-area Medicare Advantage PPO member.
- A provider that is contracted for Medicare Advantage HMO business treats an MA HMO member from the local Plan.

If you are a provider who accepts Medicare assignment and you render services to any Blue Medicare Advantage member for whom you have an obligation to provide services under your contract with a Blue Plan, you will be considered a contracted provider and be reimbursed per the contractual agreement.

Providers should make sure they understand the applicable Medicare Advantage reimbursement rules and their individual Plan contractual arrangements.

Other than the applicable member cost sharing amounts, reimbursement is made directly by a Blue Plan. In general, you may collect only the applicable cost sharing (e.g., co-payment) amounts from the member at the time of service, and may not otherwise charge or balance bill the member.

Please review the remittance notice concerning Medicare Advantage plan payment, member's payment responsibility and balance billing limitations.

4.3 Health Insurance Marketplaces (a.k.a Exchanges)

4.3.1 Health Insurance Marketplaces Overview

The Patient Protection and Affordable Care Act of 2010 provides for the establishment of Health Insurance Marketplaces (a.k.a. Exchanges), in each State, where individuals and small businesses can purchase qualified coverage. These Marketplaces will be internet websites through which eligible consumers may purchase insurance. These Marketplaces are intended to create a more organized and competitive marketplace for health insurance by offering members a choice of health insurance plans, establishing common rules regarding the offering and pricing of insurance, and providing information to help consumers better understand the options available to them. The Marketplaces will enhance competition in the health insurance market, improve choice of affordable health insurance, and give individuals and small businesses purchasing power comparable to that of large businesses.

Health Insurance Marketplaces (a.k.a. Exchanges) are expected to offer consumers a variety of health insurance plans. Product and Plan information, such as covered services and cost sharing (i.e. deductibles, coinsurance or copayments, and out-of pocket limits) will be organized in a manner that will make comparisons across health insurance plans easier for consumers. In conjunction with offering a choice of health insurance plans, the Marketplace is intended to provide consumers with transparent information about health insurance plan provisions such as premium costs and covered benefits, as well as a plan's performance in encouraging wellness, managing chronic illnesses, and improving consumer satisfaction.

Each state was given the option to set-up its own "state-based" Marketplace approved by Department of Health and Human Services for marketing products to individual consumers and small employers. If the state did not set up a state-based marketplace, the Department of Health and Human Services (HHS) has established either a Federally-facilitated Marketplace or a Federal-partnership Marketplace in the state. Blue Plans that offer products on the Marketplaces will collaborate with the state and federal governments for eligibility, enrollment, reconciliation, and other operations to ensure that consumers can seamlessly enroll in individual and employer sponsored health insurance products. Oklahoma has a Federally-facilitated Exchange. Information on the Marketplace in Oklahoma can be found at: http://www.bcbsok.com/shop-plans-and-products/2015-individual-and-family-health-insurance-plans.

4.3.2 OPM Multi-State Plan Program

Under the Affordable Care Act of 2010, the Office of Personnel Management (OPM) is required to offer OPM sponsored products on the Marketplaces (Exchanges) beginning in 2014. For a coverage effective date of Jan. 1, 2015, Blue Cross and Blue Shield Plans will participate in this program by offering these Multi-State Plans on marketplaces in 33 states and the District of Columbia. As required by the ACA, by 2017, these products will be offered across all states and D.C.

> For 2015, the following Plans will offer Multi-State Plan products: Premera (WA and AK), ARBCBS, CareFirst (MD, VA, DC), Highmark (PA, DE, and WV), HCSC (IL, TX, NM, OK, and MT), BCBSKS, BCBSLA, BCBSMA, BCBSM, BCBSMN, BCBSNC, BC NEPA, Capital BC, IBC, BCBSC, BCBSTN, and WellPoint (CA, CO, CT, GA, IN, KY, ME, MO, NV, NH, NY, VA, and WI).

These products are similar to the other Qualified Health Plan products offered on the Marketplaces. Generally, all of the same requirements that apply to other State marketplace products also apply to these Multi-State Plan products.

4.3.3 Exchange Individual Grace Period

The Patient Protection and Affordable Care Act (PPACA) mandates a three month grace period for individual members who receive a premium subsidy from the government and are delinquent in paying their portion of premiums. The grace period applies as long as the individual has previously paid at least one month's premium within the benefit year. The health insurance plan is only obligated to pay claims for services rendered during the first month of the grace period. PPACA clarifies that the health insurance plan may pend claims during the second and third months of the grace period.

Blue Plans are required to either pay or pend claims for services rendered during the second and third month of the grace period. Consequently, if a member is within the last two months of the federally mandated individual grace period, providers may receive a notification from BCBSOK indicating that the member is in the grace period.

Exchange Individual Grace Period – Post Service Notification Letter to Provider

Communication to providers will include the following information:

1. Notice-unique identification number (claim includes member information):

Claim #: _____

2. Name of the QHP and affiliated issuer (Home Plan name)

3. *Explanation of the three month grace period*:

Under the Patient Protection and Affordable Care Act (PPACA), there is a three month grace period under Exchange-purchased individual insurance policies, when a premium due is not received for members eligible for premium subsidies. During this grace period, carriers may not disenroll members and, during the second and third months of the grace period, are required to notify providers about the possibility that claims may be denied in the event that the premium is not paid.

4. Purpose of the notice, applicable dates of whether the enrollee is in the second or third month of the grace period & individuals affected under the policy and possibly under care of the provider:

Please be advised that a premium due has not been received for this subsidy eligible member and that the member and any eligible dependents are and at the time that your care was provided, were in the second or third month of the Exchange individual health insurance grace period. The above-referenced claim thus was pended due to non-payment of premium, and will be denied if the premium is not paid by the end of the grace period.

5. Consequences:

If the premium is paid in full by the end of the grace period, any pended claims will be processed in accordance with the terms of the contract. If the premium is not paid in full by the end of the grace period, any claims incurred in the second and third months may be denied.

6. QHP customer service telephone number:

Please feel free to contact [Host Plan Name] Monday through Friday, at [enter number] if you have any questions regarding this claim.

4.3.4 Health Insurance Marketplaces Claims

What else do I need to know?

The products offered on the Marketplaces will follow local business practices for processing and servicing claims. Providers should continue to follow current practices with BCBSOK for claims processing and handling such as outlined below**.**

- Eligibility and Benefits.
- Care Management.
  - Pre-Service Review.
  - Medical Policy.
- Claim Pricing and Processing.
  - Contracting.
  - Claim Filing.
  - Pricing.
  - Claim Processing.
  - Medical Records.
  - Payment.
  - Customer Service.

Who do I contact if I have a question about Health Insurance Marketplaces (Exchanges)?

If you have any questions regarding the Health Insurance Marketplaces, please contact BCBSOK at 1-866-793-8111.

4.7 International Members

The claim submission process for international Blue Plan members is the same as for domestic Blue members. You should submit the claim directly to BCBSOK. *See section 3.3 for servicing international members and the note regarding members of the Canadian Blue Cross Plans.*

4.8 Claims Coding

Code claims as you would for BCBSOK claims.

4.9 Ancillary Claims

Ancillary providers include Independent Clinical Laboratory, Durable/Home Medical Equipment and Supplies and Specialty Pharmacy providers. File claims for these providers as follows:

- Independent Clinical Laboratory (Lab)
  - The Plan in whose state the specimen was drawn based on the location of the referring provider.
- Durable/Home Medical Equipment and Supplies (D/HME)
  - The Plan in whose state the equipment was shipped to or purchased at a retail store.
- Specialty Pharmacy

- The Plan in whose state the Ordering Physician is located.

*If you contract with more than one Plan in a state for the same product type (i.e., PPO or Traditional), you may file the claim with either Plan.

Provider Type	How to file (required fields)	Where to file	Example
Independent Clinical Laboratory (any type of non hospital based laboratory) Types of Service include, but are not limited to: blood, urine, samples, analysis, etc.	**Referring Provider**: - Field 17B on CMS 1500 Health Insurance Claim Form or - Loop 2310A (claim level) on the 837 Professional Electronic	File the claim to the Plan in whose state the ***specimen was drawn**** * Where the ***specimen was drawn*** will be determined by which state the referring provider is located.	Blood is drawn* in lab or office setting located in **[enter Plan x service area].** Blood analysis is done in **[enter Plan y service area**]. *File to:* **[enter Plan x service area].** *Claims for the analysis of a lab must be filed to the Plan in whose state the ***specimen was drawn***.
Durable/Home Medical Equipment and Supplies (D/HME) Types of Service include, but are not limited to: Hospital beds, oxygen tanks, crutches, etc.	**Patient's Address**: - Field 5 on CMS 1500 Health Insurance Claim Form or - Loop 2010CA on the 837 Professional Electronic Submission. **Ordering Provider**: - Field 17B on CMS 1500 Health Insurance Claim Form or - Loop 2420E (line level) on the 837 Professional Electronic Submission. **Place of Service**: - Field 24B on the CMS 1500 Health Insurance Claim Form or - Loop 2300, CLM05-1 on the 837 Professional Electronic Submissions. **Service Facility Location Information**: - Field 32 on CMS 1500 Health Insurance Form or - Loop 2310C (claim level) on the 837 Professional Electronic Submission.	File the claim to the Plan in whose state the equipment was ***shipped to or purchased in a retail store.***	A. Wheelchair is purchased at a retail store in [**enter Plan y service area**]. *File to:* [**enter Plan y service area**] B. Wheelchair is purchased on the internet from an online retail supplier in [**enter Plan x service area]** and shipped to [**enter Plan y service area].** *File to:* [**enter Plan y service area**] C. Wheelchair is purchased at a retail store in [**enter Plan x service area]** and shipped to [**enter Plan y service area].** *File to:* [**enter Plan y service area**]

Provider Type	How to file (required fields)	Where to file	Example
Specialty Pharmacy Types of Service: Non-routine, biological therapeutics ordered by a healthcare professional as a covered medical benefit as defined by the member's Plan's Specialty Pharmacy formulary. Include, but are not limited to: injectable, infusion therapies, etc.	**Referring Provider**: - Field 17B on CMS 1500 Health Insurance Claim Form or - Loop 2310A (claim level) on the 837 Professional Electronic Submission.	File the claim to the Plan whose state the ***Ordering Physician is located***.	Patient is seen by a physician in [**enter Plan x service area**] who orders a specialty pharmacy injectable for this patient. Patient will receive the injections in **[enter Plan y service area**] where the member lives for 6 months of the year. *File to:* [**enter Plan x service area**]

- The ancillary claim filing rules apply regardless of the provider's contracting status with the Blue Plan where the claim is filed.
- Providers are encouraged to verify member Eligibility and Benefits by contacting the phone number on the back of the member ID card or call 1-800-676-BLUE, prior to providing any ancillary service.
- Providers that utilize outside vendors to provide services (example: Sending blood specimen for special analysis that cannot be done by the Lab where the specimen was drawn) should utilize in-network participating Ancillary Providers to reduce the possibly of additional member liability for covered benefits. A list of in-network participating providers may be obtained by contacting BCBSOK at 1-800-722-3730.
- Members are financially liable for ancillary services not covered under their benefit plan. It is the provider's responsibility to request payment directly from the member for non-covered services.
- Providers who wish to establish Trading Partner Agreements with other Plans should contact BCBSOK at 1-800-722-3730 to obtain additional contact information.
- If you have any questions about where to file your claim, please contact BCBSOK at 1-800-722-3730.

4.10 Contiguous Counties/Overlapping Service Areas

4.10.1 Contiguous Counties

Claims filing rules for contiguous area providers are based on the permitted terms of the provider contact, which may include:

- Provider Location (i.e. which Plan service area is the providers office located)
- Provider contract with the two contiguous counties (i.e. is the provider contracted with only one or both service areas).
- The member's Home plan and where the member works and resides (i.e. is the member's Home Plan with one of the contiguous counties plans).
- The location of where the services were received (i.e. does the member work and reside in one contiguous county and see a provider in another contiguous county).

4.10.2 Overlapping Service Areas

Submission of claims in Overlapping Service Areas is dependent on what Plan(s) the Provider contracts with in that state, the type of contract the Provider has (ex. PPO, Traditional) and the type of contract the member has with their Home Plan.

- If you contract with all local Blue Plans in your state for the same product type (i.e., PPO or Traditional), you may file an out-of-area Blue Plan member's claim with either Plan.
- If you have a PPO contract with one Blue Plan, but a Traditional contract with another Blue Plan, file the out-of-area Blue Plan member's claim by product type.
  - For example, if it's a PPO member, file the claim with the Plan that has your PPO contract.
- If you contract with one Plan but not the other, file all out-of-area claims with your contracted Plan.

4.11 Medical Records

Medical Records

Blue Plans have made many improvements to the medical records process to make it more efficient and are able to send and receive medical records electronically with other Blue Plans. This method significantly reduces the time it takes to transmit supporting documentation for our out-of-area claims, reduces the need to request records multiple times and significantly reduces lost or misrouted records.

Under what circumstances may the provider get requests for medical records for out-of-area members?

1. As part of the pre-authorization process — If you receive requests for medical records from other Blue Plans prior to rendering services, as part of the pre-authorization process, you will be instructed to submit the records directly to the member's Plan that requested them. This is the only circumstance where you would not submit them to BCBSOK.
2. As part of claim review and adjudication — These requests will come from BCBSOK in the form of a letter, fax, email, or electronic communication requesting specific medical records and including instructions for submission.

BlueCard Medical Record Process for Claim Review

1. An initial communication, generally in the form of a letter, should be received by your office requesting the needed information.
2. A remittance may be received by your office indicating the claim is being denied pending receipt and review of records. Occasionally, the medical records you submit might cross in the mail with the remittance advice for the claim indicating a need for medical records. A remittance advice is not a duplicate request for medical records. If you submitted medical records previously, but received a remittance advice indicating records were still needed, please contact BCBSOK 800-496-5774 to ensure your original submission has been received and processed. This will prevent duplicate records being sent unnecessarily.
3. If you received only a remittance advice indicating records are needed, but you did not receive a medical records request letter, contact BCBSOK to determine if the records are needed from your office.
4. Upon receipt of the information, the claim will be reviewed to determine the benefits.

Helpful Ways You Can Assist in Timely Processing of Medical Records

1. If the records are requested following submission of the claim, forward all requested medical records to BCBSOK.
2. Follow the submission instructions given on the request, using the specified physical or email address or fax number. The address or fax number for medical records may be different than the address you use to submit claims.
3. Include the cover letter you received with the request when submitting the medical records. This is necessary to make sure the records are routed properly once received by BCBSOK.
4. Please submit the information to BCBSOK as soon as possible to avoid further delay.
5. Only send the information specifically requested. Frequently, complete medical records are not necessary.
6. Please do not proactively send medical records with the claim. Unsolicited claim attachments may cause claim payment delays.

4.12 Adjustments

Contact BCBSOK if an adjustment is required. We will work with the member's Blue Plan for adjustments; however, your workflow should not be different.

4.13 Appeals

Appeals for all claims are handled through BCBSOK. We will coordinate the appeal process with the member's Blue Plan, if needed.

4.14 Coordination of Benefits (COB) Claims

Coordination of benefits (COB) refers to how we ensure members receive full benefits and prevent double payment for services when a member has coverage from two or more sources. The member's contract language explains the order for which entity has primary responsibility for payment and which entity has secondary responsibility for payment.

If you discover the member is covered by more that one health plan, and:

- BCBSOK or any other Blue Plan is the primary payer, submit other carrier's name and address with the claim to BCBSOK. If you do not include the COB information with the claim, the member's Blue Plan will have to investigate the claim. This investigation could delay your payment or result in a post-payment adjustment, which will increase your administrative burden.
- Other non-Blue health plan is primary and BCBSOK or any other Blue Plan is secondary, submit the claim to BCBSOK only after receiving payment from the primary payor, including the explanation of payment from the primary carrier. If you do not include the COB information with the claim, the member's Blue Plan will have to investigate the claim. This investigation could delay your payment or result in a post-payment adjustment, which will increase your administrative burden.

Carefully review the payment information from all payers involved on the remittance advice before balance billing the patient for any potential liability. The information listed on the BCBSOK remittance advice as "patient liability" might be different from the actual amount the patient owes you, due to the combination of the primary insurer payment and your negotiated amount with BCBSOK.

For Professional claims if the member does not have other insurance, it is imperative on the electronic HIPAA 837 claims submission transaction or CMS 1500 claim form, in box 11D, either "YES" or "NO" be checked. Leaving the box unmarked can cause the member's Plan to stop the claim to investigate for COB.

Coordination of Benefits Questionnaire

To streamline our claims processing and reduce the number of denials related to Coordination of Benefits, a Coordination of Benefits (COB) questionnaire is available to you at http://www.bcbsok.com/pdf/cob_questionnaire_form.pdf that will help you and your patients avoid potential claim issues.

When you see any Blue members and you are aware that they might have other health insurance coverage (e.g., Medicare, Community Care, Aetna), give a copy of the questionnaire to them during their visit. Providers should ensure that the form is completely filled out and at a minimum, includes your name and tax identification or NPI number, the policy holder's name, group number and identification number including the three character alpha-prefix and the member's signature. Once the form is complete, send it to your local Blue Plan as soon as possible. Your local Blue Plan will work with the member's Plan to get the COB information updated. Collecting COB information from members before you file their claim eliminates the need to gather this information later, thereby reducing processing and payment delays.

4.15 Claim Payment

- If you have not received payment for a claim, do not resubmit the claim because it will be denied as a duplicate. This will cause member confusion because of multiple Explanations

of Benefits (EOBs). BCBSOK standard time for claims processing is thirty days from the date of the receipt. However, claim processing times at various Blue Plans vary.

- If you do not receive your payment or a response regarding your payment, please call BCBSOK at 800-496-5774 or visit our Web site at Availity.com to check the status of your claim.
- In some cases, a member's Blue Plan may pend a claim because medical review or additional information is necessary. When resolution of a pended claim requires additional information from you, BCBSOK may either ask you for the information or give the member's Plan permission to contact you directly.

4.16 Claim Status Inquiry

BCBSOK is your single point of contact for all claim inquiries.

Claim status inquires can be done by:

- Phone—call BCBSOK Provider Customer Service at 800-496-5774.
- Electronically—send a HIPAA transaction 276 (claim status inquiry) to http://www.bcbsok.com/provider/claims/claim_status.html.

4.17 Calls from members and Others with Claim Questions

If other Blue Plan members contact you, advise them to contact their Blue Plan and refer them to their ID card for a customer service number.

The member's Plan should not contact you directly regarding claims issues, but if the member's Plan contacts you and asks you to submit the claim to them, refer them to BCBSOK.

4.18 Value Based Provider Arrangements

Plans have value-based care delivery arrangements in place with their providers. Each Plan has created their own arrangement with their provider(s), including reimbursement arrangements. Due to the unique nature of each Plan/provider arrangement, there is no common provider education template for value-based care delivery arrangements that can be created and distributed for use by all Plans.

4.19 Key Contacts

For more information:

- Visit the BCBSOK provider website
- Call Provider Customer Service at 800-496-5774
- Contact your BCBSOK provider service representative at 800-722-3730

5. Frequently Asked Questions

5.1 BlueCard Basics

1. What Is the BlueCard Program?

BlueCard is a national program that enables members of one Blue Plan to obtain healthcare service benefits while traveling or living in another Blue Plan's service area. The program links participating healthcare providers with the independent Blue Plans across the country and in more than 200 countries and territories worldwide through a single electronic network for claims processing and reimbursement.

The program lets you conveniently submit claims for patients from other Blue Plans, domestic and international, to your local Blue Plan.

Your local Blue Plan is your sole contact for claims payment, adjustments and issue resolution.

2. What products are included in the BlueCard Program?

The following products/claims are included in the BlueCard Program:

- Traditional (indemnity insurance)
- PPO (Preferred Provider Organization)
- HMO (Health Maintenance Organization)
- Medigap
- SCHIP (State Children's Health Insurance Plan) if administered as part of Medicaid: payment is limited to the member's Plan's state Medicaid reimbursement rates. These cards also do not have a suitcase logo. Standalone SCHIP programs will have a suitcase logo.

3. What products are excluded from the BlueCard Program?

The following products/claims are excluded from the BlueCard Program:

- Stand-alone dental
- Medicare Advantage*
- The Federal Employee Program (FEP)

Please follow BCBSOK billing guidelines.

4. What is the BlueCard Traditional Program?

It is a national program that offers members traveling or living outside of their Blue Plan's area traditional or indemnity level of benefits when they obtain services from a physician or hospital outside of their Blue Plan's service area.

5. What is the BlueCard PPO Program?

It is a national program that offers members traveling or living outside of their Blue Plan's area the PPO level of benefits when they obtain services from a physician or hospital designated as a BlueCard PPO provider.

6. Are HMO patients serviced through the BlueCard Program?

Yes, occasionally, Blue HMO members affiliated with other Blue Plans will seek care at your office or facility. You should handle claims for these members the same way as you do for BCBSOK members and Blue traditional and PPO patients from other Blue Plans by submitting them to the BCBSOK.

5.2 Identifying members and ID Cards

1. How do I identify members?

When members from Blue Plans arrive at your office or facility, be sure to ask them for their current Blue Plan membership identification card. The main identifier for out-of-area members is the alpha prefix. The ID cards may also have:

- PPO in a suitcase logo, for eligible PPO members
- Blank suitcase logo

2. What is an "alpha prefix?"

The three-character alpha prefix at the beginning of the member's identification number is the key element used to identify and correctly route claims. The alpha prefix identifies the Blue Plan or National Account to which the member belongs. It is critical for confirming a patient's membership and coverage.

3. What do I do if a member has an identification card without an alpha prefix?

Some members may carry outdated identification cards that may not have an alpha prefix. Please request a current ID card from the member.

4. How do I identify Medicare Advantage members?

Members will not have a standard Medicare card; instead, a Blue logo will be visible on the ID card. The following examples illustrate how the different products associated with the Medicare Advantage program will be designated on the front of the member ID cards:

Member ID cards for Medicare Advantage products will display one of the benefit product logos shown here:	MEDICARE ADVANTAGE | HMO	Health Maintenance Organization
	MEDICARE ADVANTAGE | MSA	Medical Savings Account
	MEDICARE ADVANTAGE | PFFS	Private Fee-For-Service
	MEDICARE ADVANTAGE | POS	Point of Service
	MA | PPO MEDICARE ADVANTAGE	Network Sharing Preferred Provider Organization.

When these logos are displayed on the front of a member's ID card, it indicates the coverage type the member has in his/her Blue Plan service area or region. However, when the member receives services outside his/her Blue Plan service area or region, provider reimbursement for covered services is based on the Medicare allowed amount, except for PPO network sharing arrangements.

BCBSOK participates in Medicare Advantage PPO Network Sharing arrangements, and contracted provider reimbursement is based on the contracted rate with BCBSOK. Non-contracted provider reimbursement is the Medicare allowed amount based on where services are rendered.

Tip: While all MA PPO members have suitcases on their ID cards, some have limited benefits outside of their primary carrier's service area. Providers should refer to the back the member's ID card for language indicating such restrictions apply.

5. How do I identify international members?

Occasionally, you may see identification cards from members residing abroad or foreign Blue Plan members. These ID cards will contain three-character alpha prefixes. Please treat these members the same as domestic Blue Plan members.

6. What do I do if a member does not have an ID card?

Contact your employer.

5.3 Verifying Eligibility and Coverage

How do I verify membership and coverage?

For BCBSOK members, visit http://www.bcbsok.com/provider/claims/index.html or call the customer service number on the back of you member ID card.

For other Blue Plan members, contact BCBSOK electronically or BlueCard Eligibility by phone to verify the patient's eligibility and coverage:

Electronic—Submit a HIPAA 270 transaction (eligibility) to BCBSOK.

Phone—Call BlueCard Eligibility 1.800.676.BLUE (2583).

5.4 Utilization Review

How do I obtain utilization review?

You should remind patients that they are responsible for obtaining pre-certification/authorization for out patient services from their Blue Plan. Effective July 1, 2014, participating providers became responsible for obtaining pre-service review for inpatient facility services when the services are required by the account or member contract (Provider Financial Responsibility). *See section 3.7, Utilization Review.*

You may also contact the member's Plan on the member's behalf. You can do so by:

For BCBSOK members, contact 800-672-2378.

For other Blue Plans members,

- Phone—Call the utilization management/pre-certification number on the back of the member's card. If the utilization management number is not listed of the back of the member's card, call BlueCard Eligibility 1.800.676.BLUE (2583) and ask to be transferred to the utilization review area.
- Electronic—Submit a HIPAA 278 transaction (referral/authorization) to BCBSOK.

See section 3.8, Electronic Provider Access

5.5 Claims

1. Where and how do I submit claims?

You should always submit claims to BCBSOK, PO Box 3283, Tulsa, OK 74102-3283. Be sure to include the member's complete identification number when you submit the claim. The complete identification number includes the three-character alpha prefix. Do not make up alpha prefixes. Claims with incorrect or missing alpha prefixes and/or member identification numbers cannot be processed.

2. How do I submit claims for international Blue members?

The claim submission process for international Blue Plan members is the same for domestic Blue Plan members. You should submit the claim directly to BCBSOK.

3. How do I handle COB claims?

If after calling 1.800.676.BLUE (2583) or through other means you discover the member has a COB provision in their benefit plan and BCBSOK is the primary payer, submit the claim with information regarding COB to BCBSOK.

If you do not include the COB information with the claim, the member's Blue Plan or the insurance carrier will have to investigate the claim. This investigation could delay your payment or result in a post-payment adjustment, which will increase your volume of bookkeeping.

4. How do I handle Medicare Advantage claims?

Submit claims to BCBSOK. Do not bill Medicare directly for any services rendered to a Medicare Advantage member. Payment will be made directly by a Blue Plan.

5. How do I handle traditional Medicare-related claims?

- When Medicare is primary payor, submit claims to your local Medicare intermediary.
- All Blue claims are set up to automatically cross over (or forward) to the member's Blue Plan after being adjudicated by the Medicare intermediary.

6. How do I submit Medicare primary / Blue Plan secondary claims?

- For members with Medicare primary coverage and Blue Plan secondary coverage, submit claims to your Medicare intermediary and/or Medicare carrier.
- When submitting the claim, it is essential that you enter the correct Blue Plan name as the secondary carrier. This may be different from the local Blue Plan. Check the member's ID card for additional verification.
- Be certain to include the alpha prefix as part of the member identification number. The member's ID will include the alpha prefix in the first three positions. The alpha prefix is critical for confirming membership and coverage, and key to facilitating prompt payments.

When you receive the remittance advice from the Medicare intermediary, look to see if the claim has been automatically forwarded (crossed over) to the Blue Plan:

- If the remittance advice indicates that the claim was crossed over, Medicare has forwarded the claim on your behalf to the appropriate Blue Plan and the claim is in process. ***DO NOT*** resubmit that claim to BCBSOK; duplicate claims will result in processing and payment delays.
- If the remittance advice indicates that the claim was not crossed over, submit the claim to BCBSOK with the Medicare remittance advice.

- In some cases, the member identification card may contain a COBA ID number. If so, be certain to include that number on your claim.
- For claim status inquiries, contact 800-676-BLUE (2583).

7. When will I get paid for claims?

The plan agrees to process all properly filed claims for covered services provided to members within 30 days from the date of the plans receipt. For additional information please refer to your BCBSOK Blue Traditional Participating Provider Agreement.

5.6 Contacts

1. Who do I contact with claims questions?

Claim Status

After submitting a claim, you can check the status online or via Provider Customer Service's automated phone system. By checking claim status, you can verify if your claim has been received, pended or finalized. Additionally, you can verify the descriptions for any claim denials.

Note: If your claim did not process the way you anticipated, it is important that you do not submit a duplicate claim for the same patient. Duplicate claims typically result in additional denials.

Checking Online

You or your billing agent can obtain **real-time results** by checking claim status through the Availity® Claim Research Tool (CRT) or your preferred vendor. The Claim Research Tool provides the equivalent of an Explanation of Benefits (EOB), including line item breakdowns and detailed denial descriptions. All results are printable and can be used as a duplicate EOB for another insurance carrier when requested.

Checking via Telephone

If you cannot submit your claim status requests online, call our Interactive Voice Response (IVR) automated phone system, 800-496-5774 available Monday through Friday, 6 a.m. to 11:30 p.m., CT, and Saturday, 6 a.m. to 6 p.m., CT. For additional details, refer to the Claim Status IVR Guide.

When running a claim status transaction, you may have additional questions if your claim did not process the way you expected. Post-processing inquiries can also be submitted online or by speaking to one of our agents.

Questions

Email our Provider Education Consultants. Be sure to include your name, direct contact information, tax ID or billing NPI.

2. How do I handle calls from members and others with claims questions?

If members contact you, tell them to contact their Blue Plan. Refer them to the front or back of their ID card for a customer service number. A member's Plan should not contact you directly, unless you filed a paper claim directly with that Plan. If the member's Plan contacts you to send it another copy of the member's claim, refer the Plan to BCBSOK.

3. Where can I find more information?

For more information:

- Visit http://www.bcbsok.com/provider.
- Call BCBSOK at 800-496-5774.
- Contact your BCBSOK provider service representative at 800-722-3730.

6. Glossary of BlueCard Program Terms

Administrative Services Only (ASO)

ASO accounts are self-funded, where the local plan administers claims on behalf of the account, but does not fully underwrite the claims. ASO accounts may have benefit or claims processing requirements that may differ from non-ASO accounts. There may be specific requirements that affect; medical benefits, submission of medical records, Coordination of Benefits or timely filing limitations.

The BCBSOK receives and prices all local claims, handles all interactions with providers, with the exception of Utilization Management interactions, and makes payment to the local provider.

Affordable Care Act

The comprehensive healthcare reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010, and
was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name
"Affordable Care Act" is used to refer to the final, amended version of the law.

Alpha Prefix

Three characters preceding the subscriber identification number on the Blue Plan ID cards. The alpha prefix identifies the member's Blue Plan or National Account and is required for routing claims.

bcbs.com

Blue Cross and Blue Shield Association's Web site, which contains useful information for providers.

BlueCard Access® 1.800.810.BLUE (2583)

A toll-free 800 number for you and members to use to locate healthcare providers in another Blue Plan's area. This number is useful when you need to refer the patient to a physician or healthcare facility in another location.

BlueCard Eligibility® 1.800.676.BLUE (2583)

A toll-free 800 number for you to verify membership and coverage information, and obtain pre-certification on patients from other Blue Plans.

BlueCard PPO

A national program that offers members traveling or living outside of their Blue Plan's area the PPO level of benefits when they obtain services from a physician or hospital designated as a BlueCard PPO provider.

BlueCard PPO member

Carries an ID card with this identifier on it. Only members with this identifier can access the benefits of the BlueCard PPO.

BlueCard Doctor & Hospital Finder Web Site

http://www.bcbs.com/healthtravel/finder.html

A Web site you can use to locate healthcare providers in another Blue Plan's area http://www.bcbs.com/healthtravel/finder.html. This is useful when you need to refer the patient to a physician or healthcare facility in another location. If you find that any information about you, as a provider, is incorrect on the Web site, please complete the BCBSOK Provider Notification form

available at www.bcbsok.com/provider/forms to submit electronically, or call OK Network Management at 800-722-3730.

BlueCard Worldwide®

A medical assistance program that provides Blue members traveling or living outside the United States, Puerto Rico and U. S. Virgin Islands with access to doctors and hospitals around the world.

Consumer Directed Healthcare/Health Plans (CDHC/CDHP)

Consumer Directed Healthcare (CDHC) is a broad umbrella term that refers to a movement in the healthcare industry to empower members, reduce employer costs, and change consumer healthcare purchasing behavior. CDHC provides the member with additional information to make an informed and appropriate healthcare decision through the use of member support tools, provider and network information, and financial incentives.

Coinsurance

A provision in a member's coverage that limits the amount of coverage by the benefit plan to a certain percentage. The member pays any additional costs out-of-pocket.

Coordination of Benefits (COB)

Ensures that members receive full benefits and prevents double payment for services when a member has coverage from two or more sources. The member's contract language gives the order for which entity has primary responsibility for payment and which entity has secondary responsibility for payment.

Co-payment

A specified charge that a member incurs for a specified service at the time the service is rendered.

Deductible

A flat amount the member incurs before the insurer will make any benefit payments.

Essential Community Providers

Healthcare providers that serve predominately low-income, high-risk, special needs and medically-underserved individuals. The Department of Health and Human Services (HHS) proposes to define essential community providers as including only those groups suggested in the ACA, namely those named in section 340B(a)(4) of the Public Health Service Act and in section 197(c)(1)(D)(i)(IV) of the Social Security Act.

FEP

The Federal Employee Program.

Hold Harmless

An agreement with a healthcare provider not to bill the member for any difference between billed charges for covered services (excluding coinsurance) and the amount the healthcare provider has contractually agreed on with a Blue Plan as full payment for these services.

Marketplace/Exchange

For purposes of this document, the term Marketplace/Exchange refers to the public exchange as established pursuant to the Affordable Care Act (ACA): A transparent and competitive insurance marketplace where individuals and small businesses can buy affordable and qualified health benefit plans. Affordable Insurance Marketplaces will offer a choice of health plans that meet certain benefits and cost standards.

The ACA allows the opportunity for each state to establish a State-based Marketplace. Recognizing that not all states may elect to establish a State-based Marketplace, the ACA directs

the Secretary of HHS to establish and operate a Federally-facilitated Marketplace in any state that does not do so, or will not have an operable Marketplace for the 2014 coverage year, as determined in 2013.

Medicaid

A program designed to assist low-income families in providing healthcare for themselves and their children. It also covers certain individuals who fall below the federal poverty level. Other people who are eligible for Medicaid include low-income children under age 6 and low-income pregnant women, Medicaid is governed by overall Federal guidelines in terms of eligibility, procedures, payment level etc, but states have a broad range of options within those guidelines to customize the program to their needs and/or can apply for specific waivers. State Medicaid programs must be approved by CMS; their daily operations are overseen by the State Department of Health (or similar state agency).

Medicare Advantage

"Medicare Advantage" (MA) is the program alternative to standard Medicare Part A and Part B fee-for-service coverage; generally referred to as "traditional Medicare."

MA offers Medicare beneficiaries several product options (similar to those available in the commercial market), including health maintenance organization (HMO), preferred provider organization (PPO), point-of-service (POS) and private fee-for-service (PFFS) plans.

Medicare Crossover

The Crossover program was established to allow Medicare to transfer Medicare Summary Notice (MSN) information directly to a payor with Medicare's supplemental insurance company.

Medicare Supplemental (Medigap)

Pays for expenses not covered by Medicare. Medigap is a term for a health insurance policy sold by private insurance companies to fill the "gaps" in original Medicare Plan coverage. Medigap policies help pay some of the healthcare costs that the original Medicare Plan doesn't cover.

Medigap policies are regulated under federal and state laws and are "standardized." There may be up to 12 different standardized Medigap policies (Medigap Plans A through L). Each plan, A through L, has a different set of basic and extra benefits. The benefits in any Medigap Plan A through L are the same for any insurance company. Each insurance company decides which Medigap policies it wants to sell.

Most of the Medigap claims are submitted electronically directly from the Medicare intermediary to the member's Home Plan via Medicare Crossover process.

Medigap does not include Medicare Advantage products, which are a separate program under the Centers for Medicare & Medicaid Services (CMS). Members who have a Medicare Advantage Plan do not typically have a Medigap policy because under Medicare Advantage these policies do not pay any deductibles, copayments or other cost-sharing.

National Account

An employer group with employee and/or retiree locations in more than one Blue Plan's Service Area.

Other Party Liability (OPL)

Cost containment programs that ensure that Blue Plans meet their responsibilities efficiently without assuming the monetary obligations of others and without allowing members to profit from illness or accident. OPL includes coordination of benefits, Medicare, Workers' Compensation, subrogation, and no-fault auto insurance.

Plan

Refers to any Blue Plan.

PPO

Preferred Provider Organization or PPO is a health benefit program that provides a significant incentive to members when they obtain services from a designated PPO provider. The benefit program does not require a gatekeeper (primary care physician) or referral to access PPO providers.

Qualified Health Plan (QHP)

Under the Affordable Care Act, starting in 2014, an insurance plan that is certified by an Exchange, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each Marketplace in which it is sold.

Small Business Health Options Program (SHOP)

Allows employers to choose the level of coverage and offer choices among health insurance plans. State-run Marketplaces are scheduled to become available by January 2014, with the federal government stepping in to run Marketplaces for states that are not ready. For 2014 and 2015, states can decide whether to include businesses with 100 or fewer, or, 50 or fewer employees in their Marketplace. In 2016, all businesses with 100 or fewer employees must be able to purchase insurance through these Exchanges. The Marketplaces have the option of including employees with more than 100 employees beginning in 2017.

State Children's Health Insurance Program (SCHIP)

SCHIP is a public program administered by the United States Department of Health and Human Services that provides matching funds to states for health insurance to families with children. The program was designed with the intent to cover uninsured children in families with incomes that are modest but too high to qualify for Medicaid. States are given flexibility in designing their SCHIP eligibility requirements and policies within broad federal guidelines. Some states have received authority through waivers of statutory provisions to use SCHIP funds to cover the parents of children receiving benefits from both SCHIP and Medicaid, pregnant women, and other adults.

Traditional Coverage

Traditional coverage is a health benefit plan that provides basic and/or supplemental hospital and medical/surgical benefits (e.g., basic, major medical and add-on riders) designed to cover various services. Such products generally include cost sharing features, such as deductibles, coinsurance or copayments.

7. BlueCard Program Quick Tips

The BlueCard Program provides a valuable service that lets you file all claims for members from other Blue Plans with your local Plan.

Here are some key points to remember:

- Make a copy of the front and back of the member's ID card.
- Look for the three-character alpha prefix that precedes the member's ID number on the ID card.
- Call BlueCard Eligibility at 1.800.676.BLUE (2583) to verify the patient's membership and coverage or use availity.com.
- Submit the paper claim to:

  BCBSOK
  P.O. Box 3283
  Tulsa, OK 74102-3283

  Always include the patient's complete identification number, which includes the three-character alpha prefix.
- For claims inquiries, providers are strongly encouraged to use availity.com, contact their preferred vendor or call BCBSOK Provider Customer Service at 800-496-5774.