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Network Summaries — Section I

Blue Cross and Blue Shield of Oklahoma Networks

The health care provider has a direct impact on the satisfaction of our members and the quality of our health benefit plans. One of our stated corporate goals is “to establish and maintain long-lasting, mutually beneficial relationships with health care providers.” The provider networks operated by Blue Cross and Blue Shield of Oklahoma form the foundation of this relationship. There are eight provider networks:

1. BlueTraditional
2. BlueChoice PPO
3. BluePreferred PPO
4. Blue Plan65 Select
5. Caring Program for Children
6. BlueWorks (Blue Cross Workplace Medical Plan Network)
7. BlueLincs HMO
8. Medicare Blue PPO

BlueTraditional
More than 11,000 health care providers representing a wide variety of specialties participate in the BlueTraditional network. Almost every acute care facility in the state participates in the BlueTraditional Network.

BlueChoice PPO
BlueChoice PPO is Oklahoma’s largest and most comprehensive PPO network. Most of the products sold by Blue Cross and Blue Shield of Oklahoma utilize the BlueChoice network.

BluePreferred PPO
Established in 1995, BluePreferred is our smallest PPO network. The quality and cost-effectiveness of the BluePreferred PPO network has created another strong managed care product to be offered to members.

Blue Plan65 Select
Blue Plan65 Select is a Medicare PPO network which offers eligible enrollees in select areas the Medicare supplemental benefits of standard Plan F with the cost-savings of a preferred provider organization. For more information about Blue Plan65 Select, refer to the Medicare Supplements topic in Section I of this manual.
Network Summaries — Section I

Caring Program for Children
The Oklahoma Caring Foundation, Inc., and its Caring Program for Children were created in 1995 by Blue Cross and Blue Shield of Oklahoma to provide access to preventive and primary outpatient health care services to eligible uninsured children. Blue Cross and Blue Shield of Oklahoma absorbs all administrative costs and matches the first $100,000 donated each year.

The success of the Caring Program for Children depends on community contributions and the participation of health care providers. Health care providers agree to provide limited benefits to program recipients for 60% of the Blue Cross and Blue Shield of Oklahoma BlueTraditional reimbursement rates. BlueTraditional health care providers are offered the opportunity to participate in this vital program.

BlueWorks (Blue Cross workplace medical plan network)
BlueWorks is a Certified Workplace Medical Plan, also known as a workers’ compensation plan. This plan is administered by GHS Property & Casualty Insurance Company, a subsidiary of Health Care Service Corporation of which Blue Cross and Blue Shield of Oklahoma is a division. For more information, refer to the GHS Property & Casualty Insurance Company section of this manual.

BlueLincs HMO
BlueLincs HMO is fully licensed by the Oklahoma Insurance Department as a health maintenance organization. BlueLincs HMO is currently accredited by Utilization Review Accreditation Corporation.

The BlueLincs network includes a combination of over 1,000 physicians and health care professionals and more than 30 hospitals. The network is available to members in both urban and rural areas of the state. The entire service area of this network includes 44 counties throughout the state (See Section I, Quick Reference, BlueLincs HMO Service Areas).

Medicare Blue PPO
The new Medicare Advantage PPO product is being promoted by CMS on a national basis as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) targeting the reform of the present Medicare program. Two of the state’s leading private insurers - Blue Cross and Blue Shield of Oklahoma and Community Care Life & Health – have joined forces to offer a new health plan option for Oklahomans eligible for Medicare.

Medicare Advantage Private Fee For Service (PFFS)
Coming in 2008 is the new program alternative to standard Medicare Part A and Part B fee-for-service coverage (generally referred to as “traditional Medicare”). It offers Medicare beneficiaries several product options, including health maintenance organization (HMO), preferred provider organization (PPO), point-of-service (POS) and private fee-for-service (PFFS) plans.
# Network and Products

This table illustrates the relationship between the networks and products of Blue Cross and Blue Shield of Oklahoma.

<table>
<thead>
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<th>BlueTraditional</th>
<th>BlueChoice</th>
<th>BluePreferred</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>BlueTraditional</td>
<td>●</td>
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<tr>
<td>BlueOptions</td>
<td>●</td>
<td>●</td>
<td>●</td>
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<tr>
<td>BlueChoice PPO</td>
<td>●</td>
<td>●</td>
<td>●</td>
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<tr>
<td>with or without</td>
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<td></td>
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<tr>
<td>an office visit</td>
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<tr>
<td>coping</td>
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<tr>
<td>Health Check</td>
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<tr>
<td>Select Care</td>
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<tr>
<td>and Children’s</td>
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<td>Major Medical</td>
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<td>Health Check</td>
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<td>●</td>
<td>●</td>
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<tr>
<td>Basic</td>
<td>●</td>
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<tr>
<td>BluePreferred</td>
<td>●</td>
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<tr>
<td>BluePreferred</td>
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<td>Personal Blue</td>
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<td>Caring Program</td>
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<td>(CPC)</td>
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<tr>
<td>Blue Plan65</td>
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<tr>
<td>Select</td>
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<td>Blue Plan65 Select</td>
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<tr>
<td>Plan65</td>
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<td>Federal Employee</td>
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<td>Program</td>
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<td>standard option</td>
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<tr>
<td>basic option</td>
<td>●</td>
<td></td>
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<tr>
<td>BlueCard program</td>
<td>●</td>
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<tr>
<td>out-of-area patient with</td>
<td>●</td>
<td></td>
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<tr>
<td>BlueCard traditional benefits</td>
<td></td>
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<td></td>
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<tr>
<td>out-of-area patient with</td>
<td>●</td>
<td></td>
<td></td>
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<tr>
<td>BlueCard PPO benefits</td>
<td></td>
<td></td>
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<tr>
<td>out-of-area patient with</td>
<td>●</td>
<td></td>
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<td>BlueCard HMO benefits</td>
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<td>GHS</td>
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<td>●</td>
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<td>●</td>
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<td>BlueLincs HMO</td>
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<td></td>
<td>BlueLincs</td>
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</table>
The illustrations of the Blue Cross and Blue Shield of Oklahoma member ID card below will help you identify your patient’s plan and coordinate patient care.

The Blue Cross and Blue Shield logo is always here.

If applicable, the employer group named here.

The member’s name, ID number and group number are noted here.

Member’s network/product is named here (reference page 3).

The BlueCard suitcase logo appears here. If the suitcase includes the “PPO” symbol, the member has PPO level benefits through BlueCard. If the suitcase is empty, the member has Traditional, Point-of-Service or HMO benefits.

The Blue Cross (hospital) plan is code and the Blue Shield Physician plan code will be on this line.

Member’s copayment amount, if applicable is noted here.

The LINCSRX band is located here, indicating the member has pharmacy benefits.

Precertification and customer service phone numbers are located on the back of the ID card. Use this number only on BCBSOK members. For out-of-state BlueCard, use 1-800-676-2583.

More LINCSRX information is located here on the back of the card.

The Blue Cross and Blue Shield of Oklahoma Web address is located here. Providers have access to a secured page at www.availity.com that can be used to verify membership and eligibility and check claims status. A password is required to use the site and an application.
Product Profiles — Section I

How to use the product profiles

The following pages contain a product profile for most Blue Cross and Blue Shield of Oklahoma products. The intent of each profile is to help you identify the patient’s plan, to provide you with an overview of patient in-network benefits and to inform you of special needs, such as precertification.

Limitations of the product profiles

- The product profiles do not verify benefit coverage for a patient.
- The profiles only contain general information. Benefit limitations and exclusions are not included.
- The product profiles only list in-network benefits. Separate deductibles and coinsurance may apply to self-referred or out-of-network care.

How to verify membership and benefit coverage

To verify membership and benefit coverage for local members, call the appropriate Provider Inquiry Unit number listed on the member’s ID card. Dialing the phone number on the ID card will help direct you to the right personnel the first time, eliminating the need to transfer your call. The Provider Inquiry Unit phone number list is found in the Quick Reference Section. For BlueCard out-of-state members, call 1-800-676-2583 to receive benefit and eligibility information.
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<td>Varies by group</td>
</tr>
<tr>
<td>Individual</td>
<td>3 x individual deductible</td>
</tr>
<tr>
<td>Family</td>
<td>Varies according to group contract</td>
</tr>
<tr>
<td>Coinsurance</td>
<td></td>
</tr>
<tr>
<td><strong>Physician services</strong></td>
<td>Subject to deductible and coinsurance</td>
</tr>
<tr>
<td><strong>Mental health services</strong></td>
<td>Benefits vary by group contract — generally subject to</td>
</tr>
<tr>
<td></td>
<td>deductible and coinsurance</td>
</tr>
<tr>
<td><strong>Hospital services</strong></td>
<td>Subject to deductible and coinsurance</td>
</tr>
<tr>
<td><strong>Provider precert requirements</strong></td>
<td>There are no provider precert contractual requirements.</td>
</tr>
<tr>
<td></td>
<td>However, there are precert requirements in the member</td>
</tr>
<tr>
<td></td>
<td>contract. As a courtesy to your patient, you are</td>
</tr>
<tr>
<td></td>
<td>encouraged to call on his or her behalf.</td>
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## BlueOptions — Section I

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<td></td>
</tr>
<tr>
<td>Benefit period deductibles</td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$500, $750, $1,000, $1,500, $2,000 $2,500 or $5,000</td>
</tr>
<tr>
<td>Family</td>
<td>3 x individual deductible</td>
</tr>
<tr>
<td>Coinsurance (after deductible is met)</td>
<td>20% if using BluePreferred network provider</td>
</tr>
<tr>
<td></td>
<td>30% if using BlueChoice network provider</td>
</tr>
<tr>
<td></td>
<td>40% if using BlueTraditional network provider</td>
</tr>
<tr>
<td></td>
<td>50% if using out-of-network provider</td>
</tr>
<tr>
<td><strong>Physician services</strong></td>
<td>$20 office visit copayment and subject to deductible and coinsurance — deductible and coinsurance are waived for all children’s office visits and the first six adult office visits per year</td>
</tr>
<tr>
<td><strong>Annual preventive care</strong></td>
<td>$150 per covered adult family member (includes routine physical, routine gynecological exams, routine tests and tetanus shots)</td>
</tr>
<tr>
<td><strong>Mental health services</strong></td>
<td>Benefits vary by group contract — generally subject to deductible and coinsurance</td>
</tr>
<tr>
<td><strong>Hospital services</strong></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>Deductible amount, per occurrence, is 50% of the plan’s annual deductible in addition to the annual deductible</td>
</tr>
<tr>
<td>Outpatient</td>
<td>$200 deductible per occurrence in addition to annual deductible</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>Additional $100 per occurrence deductible</td>
</tr>
<tr>
<td><strong>Provider precert requirements</strong></td>
<td>Refer to applicable provider contracts for precertification requirements.</td>
</tr>
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<tr>
<td>Individual</td>
<td>Varies by group</td>
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<tr>
<td>Family</td>
<td>3 x individual deductible</td>
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<tr>
<td>Coinsurance</td>
<td>Varies according to group contract</td>
</tr>
<tr>
<td><strong>Physician services</strong></td>
<td>Subject to deductible and coinsurance</td>
</tr>
<tr>
<td><strong>Mental health services</strong></td>
<td>Benefits vary by group contract — generally subject to deductible and coinsurance</td>
</tr>
<tr>
<td><strong>Hospital services</strong></td>
<td>Subject to deductible and coinsurance</td>
</tr>
<tr>
<td><strong>Provider precert requirements</strong></td>
<td>Refer to applicable provider contracts for precertification requirements.</td>
</tr>
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### BlueChoice PPO w/Office Visit Copay — Section I

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<td></td>
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<tr>
<td>Individual</td>
<td>Varies by group</td>
</tr>
<tr>
<td>Family</td>
<td>3 x individual deductible</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>Varies according to group contract</td>
</tr>
<tr>
<td><strong>Physician services</strong></td>
<td>Copays vary by group contract. Copays are listed on the member’s ID card. The office visit copay may not apply to some physician services, depending on the member contract. Services which may not be covered by an office visit copay can include surgery, psychiatric care, allergy testing and treatment, physical therapy and other services. These services are subject to the deductible and coinsurance.</td>
</tr>
<tr>
<td><strong>Mental health services</strong></td>
<td>Benefits vary by group contract — generally subject to deductible and coinsurance</td>
</tr>
<tr>
<td><strong>Hospital services</strong></td>
<td>Subject to deductible and coinsurance</td>
</tr>
<tr>
<td><strong>Provider precert Requirements</strong></td>
<td>Refer to applicable provider contracts for precertification requirements.</td>
</tr>
</tbody>
</table>
### General

**Benefit period deductibles**
- **Individual**: Varies by group
- **Family**: 3 x individual deductible
- **Coinsurance**: 20% for most covered services

<table>
<thead>
<tr>
<th>Network</th>
<th>BlueChoice PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physician services</strong></td>
<td>$15 office visit copay — the office visit copay may not apply to some physician services, depending on the member contract. Services which may not be covered by an office visit copay can include surgery, psychiatric care, allergy testing and treatment, physical therapy and other services. These services are subject to deductible and coinsurance.</td>
</tr>
<tr>
<td><strong>Mental health services</strong></td>
<td>Generally subject to deductible and coinsurance</td>
</tr>
<tr>
<td><strong>Hospital services</strong></td>
<td>Subject to deductible and coinsurance</td>
</tr>
<tr>
<td><strong>Provider precert Requirements</strong></td>
<td>Refer to applicable provider contracts for precertification requirements</td>
</tr>
</tbody>
</table>
# Health Check Basic — Section I

<table>
<thead>
<tr>
<th>Network</th>
<th>BluePreferred (to receive highest level of benefits)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General</strong></td>
<td></td>
</tr>
<tr>
<td>Benefit period deductibles</td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$500, $1,000, or $2,500</td>
</tr>
<tr>
<td>Family</td>
<td>3 x individual deductible</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>20% if using BluePreferred network provider</td>
</tr>
<tr>
<td>(after deductible is met)</td>
<td>30% if using BlueChoice network provider</td>
</tr>
<tr>
<td></td>
<td>40% if using BlueTraditional network provider</td>
</tr>
<tr>
<td></td>
<td>50% if using out-of-network provider</td>
</tr>
<tr>
<td><strong>Physician services</strong></td>
<td>$35 Copay</td>
</tr>
<tr>
<td><strong>Mental health services</strong></td>
<td>Subject to deductible and coinsurance</td>
</tr>
<tr>
<td><strong>Hospital services</strong></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>Deductible amount, per occurrence, is 50% of the plan’s annual deductible, in addition to the annual deductible</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>$200 deductible per occurrence, in addition to annual deductible</td>
</tr>
<tr>
<td>Emergency room</td>
<td>Additional $100 per occurrence deductible</td>
</tr>
<tr>
<td><strong>Provider precert</strong></td>
<td>Refer to applicable provider contracts for precertification requirements</td>
</tr>
<tr>
<td><strong>Requirements</strong></td>
<td></td>
</tr>
<tr>
<td>Network</td>
<td>Benefit period deductibles</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>General</td>
<td>Benefit period deductibles</td>
</tr>
<tr>
<td></td>
<td>Individual</td>
</tr>
<tr>
<td></td>
<td>Family</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$500, $1,000, or $2,500</td>
</tr>
<tr>
<td></td>
<td>3 x individual deductible</td>
</tr>
<tr>
<td>Physician services</td>
<td>$35 Copay</td>
</tr>
<tr>
<td>Mental health services</td>
<td>Subject to deductible and coinsurance</td>
</tr>
<tr>
<td>Hospital services</td>
<td>Deductible amount, per occurrence, is 50% of the plan’s annual deductible, in addition to the annual deductible</td>
</tr>
<tr>
<td>Inpatient</td>
<td>$200 deductible per occurrence, in addition to the annual deductible</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>$200 deductible per occurrence, in addition to the annual deductible</td>
</tr>
<tr>
<td>Emergency room</td>
<td>Additional $100 per occurrence deductible</td>
</tr>
<tr>
<td>Provider precert Requirements</td>
<td>Refer to applicable provider contracts for precertification requirements</td>
</tr>
</tbody>
</table>
### BluePreferred — Section I

<table>
<thead>
<tr>
<th>Network</th>
<th>BluePreferred PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>Varies by group</td>
</tr>
<tr>
<td>Benefit period deductibles</td>
<td>3 x individual deductible</td>
</tr>
<tr>
<td>Individual</td>
<td>Varies according to group contract</td>
</tr>
<tr>
<td>Family</td>
<td></td>
</tr>
<tr>
<td>Coinsurance</td>
<td></td>
</tr>
<tr>
<td>Physician services</td>
<td>Copays vary by group contract — copay amounts are listed on the member ID card</td>
</tr>
<tr>
<td>Mental health services</td>
<td>Benefits vary by group contract — generally subject to deductible and coinsurance</td>
</tr>
<tr>
<td>Hospital services</td>
<td>Subject to deductible and coinsurance</td>
</tr>
<tr>
<td>Provider precert Requirements</td>
<td>Refer to applicable provider contracts for precertification requirements</td>
</tr>
</tbody>
</table>

### Personal Blue — Section I

<table>
<thead>
<tr>
<th>Network</th>
<th>BlueChoice PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>$1,000</td>
</tr>
<tr>
<td>Benefit period deductibles</td>
<td>3 x individual deductible</td>
</tr>
<tr>
<td>Individual</td>
<td>20% for most covered services after deductible is met</td>
</tr>
<tr>
<td>Family</td>
<td></td>
</tr>
<tr>
<td>Coinsurance</td>
<td></td>
</tr>
<tr>
<td>Physician services</td>
<td>Subject to deductible and coinsurance</td>
</tr>
<tr>
<td>Mental health services</td>
<td>Generally subject to deductible and coinsurance</td>
</tr>
<tr>
<td>Hospital services</td>
<td>20% coinsurance after deductible met</td>
</tr>
<tr>
<td>Provider precert Requirements</td>
<td>Refer to applicable provider contracts for precertification requirements</td>
</tr>
</tbody>
</table>
BlueLincs HMO — Section I

Identification

Every BlueLincs member has an identification card, which must be presented each time he or she seeks care from a participating provider. If a BlueLincs member fails to present an identification card, BlueLincs should be contacted to verify the member’s eligibility.

Please note the following items about the member identification card:

- The patient seen must be the person listed on the card.
- The physician listed on the card is the member’s Primary Care Physician (PCP).

Eligibility can be verified by using the contact information in the Quick Reference Section of this manual.

BlueLincs member identification card

Special needs - language, vision, hearing or physically challenged

If you have patient(s) who require the services of an interpreter or who have special language needs (i.e., visually or hearing impaired) or who are physically disabled, contact BlueLincs Member Services at 1-800-580-6202.

Medical Group/PCP Membership Reports

Each month, the Medical Group/PCP will receive several computer printouts. The following is a brief description of each of these printouts.
Monthly Member List
Each PCP will receive a member list at the beginning of each month, which lists BlueLincs members who have chosen that PCP. The member’s ID number, name, age, sex, beginning BlueLincs coverage date, group number, plan type, office copay and pharmacy copay are included in this report. The PCP should check this list prior to seeing a BlueLincs member to ensure the member is assigned to that PCP. Contact BlueLincs Member Services to verify eligibility of any member who does not appear on the list.

New Enrollee Member List
At the beginning of each month, each PCP who has newly enrolled BlueLincs members for the month will receive this report. Members who have transferred to the PCP will also be included in this list. Information will include the member’s ID number, name, sex, age, address, plan type, office copay, pharmacy copay, group number, effective date with the PCP, and designation for new member (E) or physician transfer (T). PCPs will receive this list only when they have BlueLincs members in this category.

Disenrolled Member List
At the beginning of each month, each PCP who has a disenrolled member for the month will receive this list. Members who have transferred to another PCP will also be included in this list. Information will include the member’s ID number, sex, age, plan type, office copay, pharmacy copay, group number, effective date, and designation for disenrollment (D) or physician transfer (T). PCPs will receive this list only when they have BlueLincs members in this category.

Detailed Capitation Report
This report will be distributed with the monthly capitation check issued about the 20th of each month. It will give a detailed listing of each BlueLincs member for which the PCP is receiving capitation for that month. (Capitation is computed based on members assigned to the PCP as of the 15th of each month.)

Retroactive Adjustment Detail Report
This report will be included with the monthly capitation checks only if the PCP has retroactive capitation adjustments (negative or positive).

Summary Capitation Report
This report summarizes the information on the Detail Capitation Report and the Retroactive Adjustment Detail Report. Total capitation payments for the month will be shown on this report.

If you have questions on the above reports, contact the Health Industry Relations Department.
The Away From Home Care Program

Member Identification
Away From Home Care Program members visiting Oklahoma will have BlueLincs Identification Cards, and they will be assigned to a PCP.

Member Access
Away From Home Care Program members have access to the The Away From Home Care Program if they intend to stay out of their HMO service area for a period of at least 90 consecutive days. Members must give 30 days prior notice that they wish to participate in The Away From Home Care Program by calling 1-800-580-6202.

The Benefit
The Away From Home Care Program is designed for members who intend to spend an extended period of time away from home (outside their HMO service area). The Away From Home Care Program provides a temporary registration in a participating HMO. This entitles the member to a comprehensive set of member benefits and services.

Referrals and Precertification
Assigned PCPs treating an Away From Home Care Program member do not need to obtain a referral. PCPs wanting to refer an Away From Home Care Program member to a specialist should follow the established standards set forth in Section II.

Claims and Reimbursement
Claims should be mailed directly to BlueLincs.

BlueLincs AFHC Coordinator
P.O. Box 21128
Tulsa, OK  74121
Caring Program for Children — Section I

What is the Caring Program for Children?

The Oklahoma Caring Foundation, Inc., and its Caring Program for Children were created in 1995 by Blue Cross and Blue Shield of Oklahoma to provide access to preventive and primary outpatient health care services to eligible uninsured children. These children do not usually see a doctor until there is an emergency. Even then, their parents often lack the funds to pay for the care. With the Caring Program for Children, these children receive the preventive and primary care they need, reducing the chance they’ll end up in an emergency situation.

How does the Caring Program work?

The Caring Program for Children is funded through The Oklahoma Caring Foundation, Inc., a non-profit public charity. Blue Cross and Blue Shield of Oklahoma administers both the program and the charity as an in-kind contribution. Contributions made by concerned organizations and individuals pay for the children’s health care services. Since Blue Cross and Blue Shield of Oklahoma absorbs all administrative costs, every donated dollar is spent on health care for a child. In addition, Blue Cross and Blue Shield of Oklahoma matches the first $100,000 donated each year.

Who is eligible for the Caring Program?

- Unmarried Oklahoma residents from birth through age 18 living with at least one parent or legal guardian
- Must be ineligible for Medicaid or other government programs and not currently enrolled in a private health insurance plan
- Family’s gross annual income must meet program guidelines
- Child must be enrolled in school, if of school age

The health care provider’s role

The success of the Caring Program for Children depends on community contributions and participation of providers. Providers agree to provide limited benefits to program recipients for 60% of the Blue Cross and Blue Shield of Oklahoma BlueTraditional reimbursement rates.

How to verify membership and eligibility

Enrollees are issued a member ID card. To verify the enrollee’s membership and benefit coverage, call Member Services at the appropriate phone number listed in the Quick Reference Section.
Caring Program for Children — Section I

Do you know a child who may qualify for the Caring Program?

Please call Member Services at the phone number listed above to request application forms.

Caring Program contributions

Children are financially sponsored by private sector donations to The Oklahoma Caring Foundation, Inc., a 501(c) (3) tax exempt organization. To make a contribution, please call (918) 551-3403.

Important notes

- Any services rendered by an out-of-network provider are not covered benefits
- Inpatient services are not covered by the Caring Program for Children
## Caring Program for Children — Section I

<table>
<thead>
<tr>
<th>Network</th>
<th>Oklahoma Caring Program</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General</strong></td>
<td></td>
</tr>
<tr>
<td>Deductibles</td>
<td>None</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>Physician services</strong></td>
<td></td>
</tr>
<tr>
<td>Routine office visit</td>
<td>Allowed charges paid in full</td>
</tr>
<tr>
<td>Annual exam, well-child</td>
<td>Allowed charges paid in full</td>
</tr>
<tr>
<td>visits and immunizations</td>
<td>Allowed charges paid in full</td>
</tr>
<tr>
<td>In-office lab and x-rays</td>
<td>Allowed charges paid in full</td>
</tr>
<tr>
<td><strong>Mental health services</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not a covered benefit</td>
</tr>
<tr>
<td><strong>Hospital services</strong></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>Not a covered benefit</td>
</tr>
<tr>
<td>Emergency room copay</td>
<td>$10</td>
</tr>
<tr>
<td>Limited outpatient surgery</td>
<td></td>
</tr>
<tr>
<td>Tonsil or adenoid removal</td>
<td></td>
</tr>
<tr>
<td>Hernia repair</td>
<td>Allowed charges paid in full</td>
</tr>
<tr>
<td>Insertion of ear tubes</td>
<td>Allowed charges paid in full</td>
</tr>
<tr>
<td><strong>Prescription drug benefit</strong></td>
<td></td>
</tr>
<tr>
<td>Generic copay at participating pharmacy</td>
<td>$3</td>
</tr>
<tr>
<td>Brand name copay at participating pharmacy</td>
<td>$8</td>
</tr>
<tr>
<td>Calendar year maximum</td>
<td>$100</td>
</tr>
</tbody>
</table>

**Provider precert requirements** | None  

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**Blue Cross and Blue Shield of Oklahoma Provider Blueprint Manual (05/08)**  
18
The Medicare Program — Section I

What is Medicare?

Medicare is a federal health benefit plan for eligible people age 65 or older, people with certain disabilities and people of all ages with End-Stage Renal Disease. The Medicare program is administered by the Centers for Medicare and Medicaid Services (CMS) (formerly known as Health Care Financing Administration) an agency in the Department of Health and Human Services.

Medicare is divided into parts — Part A and Part B offer benefits for specific medical services or supplies.

Part A — Hospital Insurance
- Inpatient hospital care
- Skilled nursing facility (not custodial or long-term care)
- Home health care
- Hospice care

Part B — Medical Insurance
- Doctors’ services
- Outpatient hospital services
- Durable medical equipment
- Additional limited medical supplies and services not covered by Part A (Intermediaries also process some Part B claims.)

In general, enrollees do not pay a premium for Part A coverage. Part A benefits are subject to deductibles and coinsurance. Enrollees do pay a premium for Part B coverage, and Part B benefits are also subject to separate deductibles and coinsurance.

Carriers and intermediaries

The Centers for Medicare and Medicaid Services contract with private insurance companies to handle claims processing, payment, audits, medical review and customer service for Medicare beneficiary claims. Companies who handle Part B claims are called Carriers. Companies who handle Part A claims are called Intermediaries.

Since the inception of the Medicare program in 1966, Blue Cross and Blue Shield of Oklahoma has contracted with the federal government as a Medicare Part A Intermediary, processing and paying Medicare Part A claims for most Oklahoma-area facilities. Blue Cross and Blue Shield of Oklahoma operates the Medicare program under the Chisholm Administrative Services division. Under the Medicare Modernization Act of 2003, CMS began a recontracting process that is resulting in termination of most Medicare Part A and B carrier and intermediary
arrangements and execution of new Medicare Administrative Contracts in 14 regions. Effective March 1, 2008, Chisholm Administrative Services will transition the Medicare Part A processing and payment services to TrailBlazer, the new Part A and B Medicare Administrative Contractor for the region which includes Oklahoma.

Please refer to Billing & Reimbursement for the claims mailing address and additional claims information.

**Medicare supplements or “Medigap” policies**

Medicare does not cover all medical expenses. As a result, health benefit plans have been developed to supplement Medicare coverage. The Medicare supplements are also known as “Medigap” policies, because they fill in the benefit gaps left open by Medicare. Blue Cross and Blue Shield of Oklahoma offers two Medigap policies — Plan65 (with 12 options) and Blue Plan65 Select.

**Plan65**

The federal government has standardized the type of Medigap policies available to Medicare enrollees. Currently, there are 12 standard options. Blue Cross and Blue Shield of Oklahoma offers all 12 standard options under the Plan65 program. Each option is indicated by a letter of the alphabet — Plan A through Plan L. Plan A is the basic benefits package. Plan J provides the most comprehensive supplemental coverage.

Before Medigap policies were standardized, Blue Cross and Blue Shield of Oklahoma offered six different Medicare supplements — Options 1-5 and Option 7 (there is no Option 6). Although these options are no longer available to new enrollees, many Oklahomans who purchased Options 1-5 and Option 7 in the past are still covered under these policies. This manual includes benefit summaries for Plans A-L, in addition to Options 1-5 and Option 7.

**Blue Plan65 Select**

Available in limited areas, Blue Plan65 Select offers eligible enrollees Medigap benefits with the cost savings of a preferred provider organization. Unlike traditional Plan65 members, members with Blue Plan65 Select coverage choose health care providers and facilities from an exclusive Blue Plan65 Select network. As a result of this partnership, Blue Cross and Blue Shield of Oklahoma is able to offer Blue Plan65 Select members the Medigap benefits of the standard Plan F at a lower cost.
**MEDICARE BLUE Rx**

BCBSOK offers a Medicare Prescription Drug Plan that contracts with Medicare.

The plan does not cover drugs that are covered under Medicare Part B as prescribed and dispensed. Generally, this plan only covers drugs, vaccines, biological and medical supplies that are covered under the Medicare Prescription Drug Benefit (Part D) and that are on the BCBSOK formulary list. For a complete summary of benefits, please visit our website at www.bcbsok.com.

**Medicare Blue PPO**

The new Medicare Advantage PPO product is being promoted by CMS on a national basis as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) targeting the reform of the present Medicare program.

Medicare beneficiaries in 21 approved counties throughout central and eastern Oklahoma may choose Medicare Blue PPO, an individual Medicare Advantage PPO health plan. The service area includes: Canadian, Cleveland, Creek, Delaware, Grady, Logan, Lincoln, Mayes, McClain, Muskogee, Oklahoma, Okmulgee, Osage, Pawnee, Payne, Pottawatomie, Rogers, Sequoyah, Tulsa, Wagoner and Washington Counties.

Medicare Blue PPO was approved as a Medicare Advantage Organization and began offering our Blue Cross and Blue Shield branded network on August 1, 2005. The product is underwritten by Blue Cross and Blue Shield of Oklahoma and administrated by Community Care Life and Health Insurance Company. Most of the product’s administrative functions, including customer service, claims and medical management services, are performed by Community Care Life & Health Insurance Company.

Medicare Advantage plans like Medicare Blue PPO take the place of traditional Medicare Part A (hospital coverage) and Medicare Part B (physician coverage). Members who select this plan are prohibited from enrolling in a supplemental plan. Medicare Blue PPO features a preferred provider organization (PPO) network including hospitals, doctors and other health care providers. Members receive the highest level of benefits available when they seek care within the Medicare Blue PPO network.

Reimbursement to the provider is based on Medicare methodology and payment is made on a fee for service basis. A separate provider manual is available to participating providers by contacting Health Industry Relations. Further, a printable participating provider directory is available at Medicare Blue PPO’s website at www.ccok.com.
The Medicare Program — Section I

Medicare supplements and precertification

For members who have supplementary Medicare benefits through Blue Plan65 Select, precertification through Blue Cross and Blue Shield of Oklahoma for all inpatient admissions is required when Medicare Part A benefits have been exhausted. See the Quick Reference Section for the precertification number.

How to use the product profiles

The following pages contain a product profile for Blue Plan65 Select, Plan65 Plans A-L and Plan65 Options 1-5 and 7. The intent of each profile is to help you identify the patient’s plan and to provide an overview of benefits.

Limitations of the product profiles

- The product profiles do not verify benefit coverage for a patient.
- The profiles only contain general information. Benefit limitations and exclusions are not included.

How to verify membership and benefit coverage

To verify membership and benefit coverage for a Plan65 or Blue Plan65 Select member, call Plan65 customer service listed in the Quick Reference Section. A summary of benefits is listed below. For a current list visit the Medicare website.
### Blue Plan65 Select — Section I

<table>
<thead>
<tr>
<th>Service</th>
<th>Medicare Benefits</th>
<th>Blue Plan65 Select Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient hospital fees</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Days 1-60</td>
<td>All but $952</td>
<td>$952 per day</td>
</tr>
<tr>
<td>Days 61-90</td>
<td>$238 per day</td>
<td>$238 per day</td>
</tr>
<tr>
<td>Days 91-150</td>
<td>All but $476 per day</td>
<td>$476 per day</td>
</tr>
<tr>
<td>Beyond day 150</td>
<td>No benefit</td>
<td>100% of approved charges for additional 365 days</td>
</tr>
<tr>
<td><strong>Blood deductible</strong></td>
<td>All but first three pints</td>
<td>100% of approved charges for first three pints</td>
</tr>
<tr>
<td><strong>Skilled nursing facility</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(post-hospital)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day 1-20</td>
<td>100% of all charges</td>
<td>Not applicable</td>
</tr>
<tr>
<td>21-100</td>
<td>All but $119 per day</td>
<td>Up to $119 per day</td>
</tr>
<tr>
<td><strong>Part B services and supplies</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First $124 of approved amounts</td>
<td>No benefit</td>
<td>First $124 of approved amounts</td>
</tr>
<tr>
<td>Remaining approved amounts</td>
<td>80%</td>
<td>Remaining 20%</td>
</tr>
<tr>
<td>Excess charges</td>
<td>No benefit</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Foreign travel emergency care</strong></td>
<td>No benefit</td>
<td>80% of approved charges after First $250</td>
</tr>
<tr>
<td><strong>At home recovery services</strong></td>
<td>No benefit</td>
<td>$50,000 life maximum</td>
</tr>
<tr>
<td><strong>Prescription drugs</strong></td>
<td>No benefit</td>
<td>No benefit</td>
</tr>
<tr>
<td><strong>Preventive care</strong></td>
<td>No benefit</td>
<td>No benefit</td>
</tr>
</tbody>
</table>

- This table summarizes in-network benefits only. Blue Plan65 Select utilizes the Blue Plan65 Select network.
- Inpatient admissions require precertification when Medicare Part A benefits have been exhausted.
- Foreign travel emergency care is for services beginning the first 60 days of each trip outside the United States.
### Plan65 Plan A-L — Section I

#### Outline Of Medicare Supplement Coverage – Cover Page: 1 of 2

**Benefits Plans A - L**

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
<th>I</th>
<th>J*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic</td>
<td>Benefits</td>
<td>Basic</td>
<td>Benefits</td>
<td>Basic</td>
<td>Benefits</td>
<td>Basic</td>
<td>Benefits</td>
<td>Basic</td>
<td>Benefits</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>Contraception</td>
<td>Part A</td>
<td>Deductible</td>
<td>Part A</td>
<td>Deductible</td>
<td>Part A</td>
<td>Deductible</td>
<td>Part A</td>
<td>Deductible</td>
</tr>
<tr>
<td>Part B</td>
<td>Deductible</td>
<td>Part B</td>
<td>Excess (100%)</td>
<td>Part B</td>
<td>Excess (100%)</td>
<td>Part B</td>
<td>Excess (100%)</td>
<td>Part B</td>
<td>Excess (100%)</td>
</tr>
<tr>
<td>Foreign Travel Emergency</td>
<td>At-Home Recovery</td>
<td>Preventive Care NOT covered by Medicare</td>
<td>Preventive Care NOT covered by Medicare</td>
<td>Preventive Care NOT covered by Medicare</td>
<td>Preventive Care NOT covered by Medicare</td>
<td>Preventive Care NOT covered by Medicare</td>
<td>Preventive Care NOT covered by Medicare</td>
<td>Preventive Care NOT covered by Medicare</td>
<td>Preventive Care NOT covered by Medicare</td>
</tr>
</tbody>
</table>

*Plans F and J also have an option called a high deductible Plan F and a high deductible Plan J. These high deductible plans pay the same benefits as Plans F and J. You have the option of choosing the high deductible plan. After you have reached the Medicare deductibles for Plans F and J, your out-of-pocket expenses are $1,790. Out-of-pocket expenses for the high deductible plans pay the same benefits as Plans F and J. If you choose the high deductible plans, you will not have the same level of coverage as Plans F and J.*
Basic Benefits for Plans K and L include similar services as plans A-J, but cost-sharing for the Basic Benefits is at different levels.

<table>
<thead>
<tr>
<th></th>
<th>J</th>
<th>K**</th>
<th>L**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Benefits</td>
<td>100% of Part A Hospitalization Coinsurance plus coverage for 365 days after Medicare Benefits end</td>
<td>100% of Part A Hospitalization Coinsurance plus coverage for 365 days after Medicare Benefits end</td>
<td>75% Hospice cost-sharing</td>
</tr>
<tr>
<td></td>
<td>50% Hospice cost-sharing</td>
<td>75% Hospice cost-sharing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>50% of Medicare-eligible expenses for the first three pints of blood</td>
<td>75% of Medicare-eligible expenses for the first three pints of blood</td>
<td></td>
</tr>
<tr>
<td></td>
<td>50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services</td>
<td>75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services</td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing Coinsurance</td>
<td>50% Skilled Nursing Facility Coinsurance</td>
<td></td>
<td>75% Skilled Nursing Facility Coinsurance</td>
</tr>
<tr>
<td>Part A Deductible</td>
<td>50% Part A Deductible</td>
<td></td>
<td>75% Part A Deductible</td>
</tr>
<tr>
<td>Part B Deductible</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Part B Excess (100%)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foreign Travel Emergency</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>At-Home Recovery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Care NOT covered by Medicare</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>$4,000 Out of Pocket Annual Limit***</td>
<td></td>
<td>$2,000 Out-of-Pocket Annual Limit***</td>
</tr>
</tbody>
</table>

**Plans K and L provide for different cost-sharing for items and services than Plans A-J.**
Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your Provider that exceed Medicare-approved amounts, called "Excess Charges". You will be responsible for paying excess charges.

***The out-of-pocket annual limit will increase each year for inflation.
Federal Employee Program (FEP) — Section I

What is FEP?

Blue Cross and Blue Shield of Oklahoma administers the health benefit plan for eligible federal employees and retirees in the area. This contractual arrangement with the federal government is known as the Federal Employee Program (FEP).

How does FEP work?

On behalf of the many independent Blue Cross and Blue Shield Plans, the Blue Cross and Blue Shield Association contracts with the Office of Personnel Management (OPM) to provide health benefits to eligible federal employees and retirees as authorized by the Federal Employees Health Benefits (FEHB) law. The Blue Cross and Blue Shield Association is the carrier, and health benefits are administered by independent participating Blue Cross and Blue Shield Plans. The independent Plans are subject to strict federal regulation. The health benefit plan is known as the Blue Cross and Blue Shield Service Benefit Plan.

Member benefit options

FEP participants may choose one of two options in the Federal Employee Program:

1. Standard Option
2. Basic Option

How to use the product profiles

The following pages contain a product profile and member ID card illustration for Standard Option and Basic Option. The intent of each profile is to help you identify the patient’s plan and to provide an overview of benefits.

- The product profiles do not verify benefit coverage for a patient.
- The profiles only contain general information. Benefit limitations and exclusions are not included.
- Benefit profiles list in-network benefits only. Benefits are reduced when the member seeks care out-of-network or opts for self-referred care.

How to verify membership and benefit coverage

To verify membership and benefit coverage for an FEP member, call the FEP Provider Inquiry Unit number listed in the Quick Reference Section of this manual.
Federal Employee Program (FEP) — Section I

FEP member ID card information

Identification cards for FEP members are issued through a federal office in Washington, D.C.

FEP member ID numbers have an “R” prefix followed by eight numeric digits. Make a copy of the member’s ID cards, and be sure to record the exact member ID number on all claims and documentation. The ID number is not based on the social security number. Do not try to guess the member ID number.

Federal form 2809 is proof of enrollment when a member has not yet received an ID card from the Washington, D.C., office.
### Federal Employee Program (FEP) — Section I

<table>
<thead>
<tr>
<th>Network</th>
<th><strong>Standard Option</strong></th>
<th><strong>Basic Option</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventative care and Routine physical exams</td>
<td>BlueChoice</td>
<td>$15 copay</td>
</tr>
<tr>
<td>Office Visit</td>
<td></td>
<td>No charge</td>
</tr>
<tr>
<td>Preventative screenings</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Physician Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient services, including surgery &amp; medical care &amp; outpatient surgery</td>
<td>90% Maximum Reimbursement Allowance (MRA) after $250 deductible</td>
<td>$100 copay per surgeon</td>
</tr>
<tr>
<td></td>
<td>$15 copay</td>
<td>$20 office visit copay</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$30 copay for specialist</td>
</tr>
<tr>
<td><strong>Mental health and substance abuse</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient professional services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Authorization</td>
<td>$15 office visit copay</td>
<td>$20 office visit copay</td>
</tr>
<tr>
<td>Precertification</td>
<td>Magellan Behavioral Health 1-877-906-6389 Treatment Plan Required prior to ninth visit</td>
<td>Magellan Behavioral Health 1-800-906-6389 Treatment Plan</td>
</tr>
<tr>
<td></td>
<td>All care must have prior approval</td>
<td></td>
</tr>
<tr>
<td><strong>Hospital Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient hospital care</td>
<td>$100 per admission copayment for unlimited days</td>
<td></td>
</tr>
<tr>
<td>Emergency care</td>
<td>10% of MRA if rendered within 72 hours of accidental injury</td>
<td>$50 copay</td>
</tr>
<tr>
<td></td>
<td>90% of MRA</td>
<td>$40 copay</td>
</tr>
<tr>
<td>Outpatient hospital surgery or ambulatory surgery center</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Chiropractic care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spinal manipulations</td>
<td>No benefit</td>
<td>No benefit</td>
</tr>
<tr>
<td><strong>Catastrophic benefits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>100% payment level after $4,000 of out-of-pocket coinsurance, copay and deductible expenses</td>
<td>100% payment level after $5,000 of out-of-pocket coinsurance, copay expenses</td>
</tr>
</tbody>
</table>

- Acupuncture services are available only by a physician
BlueCard® Program — Section I

Understanding the BlueCard program

The BlueCard Program is a national program that enables members to obtain health care services while traveling or living in another Blue Cross and Blue Shield (BCBS) Plan’s area. Members receive all the same benefits of their contracting Blue Plan and access to providers and savings. The program links participating health care providers and independent Blue Plans across the country and around the world through a single electronic network for claims processing and reimbursement. If you are unsure about your participation status, please contact Blue Cross and Blue Shield of Oklahoma, Health Industry Relations.

Advantages of the BlueCard program

The BlueCard® Program allows you to submit claims for members from other Blue Plans, including international Blue Plans, directly to Blue Cross and Blue Shield of Oklahoma. Blue Cross and Blue Shield of Oklahoma will be your one point of contact for most of your claims related questions.

How do I identify BlueCard members?

When members from other Blue Cross and Blue Shield Plans arrive at your office or facility, be sure to ask them for their current Blue Plan membership identification card. The main identifiers for BlueCard members are the alpha prefix, an empty suitcase logo, and, for eligible PPO members, the “PPO in a suitcase” logo. If the suitcase is empty, the member utilizes the BlueTraditional network.

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 out-of-area claims. The alpha prefix identifies the Blue Cross and Blue Shield Plan or national account to which the member belongs. It is critical for confirming a patient’s membership and coverage.

International alpha prefixes

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

Identification cards with no alpha prefix

Some identification cards may not have an alpha prefix. This may indicate the claims are handled outside the BlueCard Program. Please look for instructions or a telephone number on the back of the member’s ID card for how to file these claims. If that information is not available, call Blue Cross and Blue Shield of Oklahoma.
BlueCard® Program — Section I

Empty suitcase logo
An empty suitcase logo on a member’s ID card means that the patient has Blue Cross and Blue Shield traditional, POS, or HMO benefits delivered through the BlueCard Program. Members with this logo on their ID card will access the BlueTraditional network.

“PPO in a suitcase” logo
You can recognize BlueCard PPO members by the special “PPO in a suitcase” logo on their membership card. BlueCard PPO members are Blue Cross and Blue Shield members whose PPO benefits are delivered through the BlueCard Program. Only those PPO members whose membership cards carry this logo are eligible for this BlueCard PPO program. Members traveling or living outside of their Blue Plan's area receive the PPO level of benefits when they obtain services from designated BlueCard PPO providers. Members with this logo on their ID card will access the BlueChoice PPO network.

Claims and products in the BlueCard program
The BlueCard Program applies to all inpatient, outpatient and professional claims.

- Traditional, PPO and HMO products are included in the BlueCard program.

The BlueCard program does not apply to stand-alone dental and prescription drugs (local plan variations may apply).

Accounts exempt from the BlueCard program
Claims for the Federal Employee Program (FEP) are exempt from the BlueCard program. Please follow your FEP billing guidelines.

Products included in the BlueCard program

BlueCard Traditional
BlueCard Traditional is a national program that offers members traveling or living outside of their Blue Plan’s area the traditional, or indemnity level of benefits when they obtain services from a physician, hospital or other health care providers outside of their Blue Plan’s service area.

BlueCard PPO
BlueCard PPO is a national program offering members traveling or living outside of their Blue Plan’s area the PPO level of benefits when they obtain services from a physician, hospital or other health care providers designated as a Blue Cross and Blue Shield of Oklahoma PPO provider.
**BlueCard® Program — Section I**

**HMO patient services through the BlueCard program**

Blue Cross and Blue Shield (BCBS) HMO members affiliated with other Blue Plans are able to seek care at your office or facility through BlueCard. You should handle claims for these members the same way as you do Blue Cross and Blue Shield of Oklahoma members and BCBS traditional, PPO and POS patients from other BluePlans — by submitting them to Blue Cross and Blue Shield of Oklahoma.

**How to verify eligibility and benefits**

1. Have the member’s ID card ready when calling.

2. Call **1-800-676-BLUE** (2583) to verify the patient’s membership and coverage. Operators are available to assist you weekdays during regular business hours. They will ask for the alpha prefix shown on the patient’s ID card. That information is the key to transferring your call to the Blue Plan where the patient is enrolled.

3. Keep a copy of the front and back of the ID card for future reference. Keep in mind that Plans are located throughout the country and may operate on a different time schedule than Blue Cross and Blue Shield of Oklahoma.

Patients from other Blue Plans are responsible for obtaining precertification/preauthorization for their services from their Blue Cross and Blue Shield Plan. You may also choose to contact the member’s Plan on behalf of the member. If you choose to do so, ask to be transferred to the utilization review area when calling BlueCard **Eligibility** (1-800-676-BLUE) for membership and coverage information.

**Where and how do I submit BlueCard program claims?**

You should always submit BlueCard claims to Blue Cross and Blue Shield of Oklahoma. 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 member identification numbers will be returned.

Once Blue Cross and Blue Shield of Oklahoma receives a claim, it will price the claims in accordance with the applicable Blue Cross and Blue Shield of Oklahoma network agreement and then electronically route the claim to the member’s Blue Cross and Blue Shield Plan. The member’s Plan then processes the priced claim and approves payment, which will be reflected on your Blue Cross and Blue Shield of Oklahoma Explanation of Claims Summary.
International claims
The claim submission process for international Blue Cross and Blue Shield Plan members is the same as for domestic Blue Cross and Blue Shield Plan members. You should submit the claim directly to Blue Cross and Blue Shield of Oklahoma.

Indirect, support or remote providers
If you are a health care provider that offers products, materials, informational reports and remote analysis or services, and are not present in the same physical location as a patient, you are considered an indirect, support or remote provider. Examples include, but are not limited to, prosthesis manufacturers, durable medical equipment suppliers, independent or chain laboratories, or telemedicine providers.

If you are an indirect provider for members from multiple Blue Plans, follow these claim filing rules:

- If you normally send claims to the direct provider of care, follow normal procedures.
- If you do not normally send claims to the direct provider of care, file with your local Blue Cross and Blue Shield of Oklahoma Plan.

Exceptions to BlueCard claims submissions
Occasionally, exceptions may arise in which Blue Cross and Blue Shield of Oklahoma will require you to file the claim directly with the member’s Blue Plan. Here are some of those exceptions:

- You contract with the member’s Blue Plan (for example, in contiguous county or overlapping service area situations).
- The ID card does not include an alpha prefix.
- A claim is returned to you from Blue Cross and Blue Shield of Oklahoma because no alpha prefix was included on the original claim that was submitted. When in doubt, please send the claim to Blue Cross and Blue Shield of Oklahoma, and we will handle the claim for you.

Claims for accounts not eligible for the BlueCard program
When a member belongs to an account that is not eligible for the BlueCard Program, Blue Cross and Blue Shield of Oklahoma will electronically forward your claims to the member’s Blue Plan. That means you will no longer need to send paper claims directly to the member’s Blue Plan. Instead, submit these claims to Blue Cross and Blue Shield of Oklahoma. However, you should continue to submit Medicare supplemental (Medigap) and other Coordination of Benefits (COB) claims under your current process.
BlueCard® Program — Section I

How the Electronic Process Works
1. You will submit these claims with alpha prefixes not eligible for BlueCard directly to Blue Cross and Blue Shield of Oklahoma, which will forward the claims to the member’s Plan for you.
   - It is important for you to call BlueCard Eligibility at 1-800-676-BLUE to verify the member’s eligibility and coverage.
   - It is also important for you to correctly capture on the claim the member’s complete identification number, including the three-character alpha prefix at the beginning. If you don’t include this information, Blue Cross and Blue Shield of Oklahoma may return the claim to you, and this will delay claims resolution and your payment.

2. If the member’s claim is not eligible for the BlueCard Program, Blue Cross and Blue Shield of Oklahoma will inform you that the claim is being forwarded to the member’s Plan.
   - In most cases, the member’s Blue Plan will contact you for additional information. For example, if the member’s Plan can’t identify the member, the member’s Blue Plan may return the claim to you just as it would currently with a paper claim. If this happens, you will need to check and verify the billing information and resubmit the claim with additional/corrected information to Blue Cross and Blue Shield of Oklahoma.

3. The member’s Blue Plan will send you a detailed Explanation of Benefits (EOB)/payment advice with your payment or will send a notice of denial.

4. If you submit electronically, your vendor must have executed a Trading Business Partner Agreement with Blue Cross and Blue Shield of Oklahoma as required by the Health Insurance Portability and Accountability Act (HIPAA).

Coordination of Benefits
Coordination of Benefits (COB) refers to how we make sure people receive full benefits and prevent 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. If after calling 1-800-676-BLUE or through other means you discover the member has a COB provision in their benefit plan, and the Blue Cross and Blue Shield Plan is the primary payer, submit the claim along with information regarding COB to Blue Cross and Blue Shield of Oklahoma. 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 volume of bookkeeping.
BlueCard® Program — Section I

Medicare supplemental (Medigap) claims

For Medicare supplemental claims, always file with the Medicare contractor first. Always include the complete Health Insurance Claim Number (HICN); the patient’s complete Blue Cross and Blue Shield identification number, including the three-character alpha prefix; and the Blue Cross and Blue Shield name as it appears on the patient’s ID card, for supplemental insurance. This will ensure cross-over claims are forwarded appropriately. Do not file with Blue Cross and Blue Shield of Oklahoma and Medicare simultaneously. Wait until you receive the Explanation of Medical Benefits (EOMB) or payment advice from Medicare. After you receive the Medicare payment advice/EOMB, determine if the claim was automatically crossed over to the supplemental insurer.

Cross-over Claims
If the claim was crossed over, the payment advice/EOMB should typically have Remark Code MA 18 printed on it, which states, “The claim information is also being forwarded to the patient’s supplemental insurer. Send any questions regarding supplemental benefits to them.” The code and message may differ if the contractor does not use the ANSI X12 835 payment advice. If the claim was crossed over, do not file for the Medicare supplemental benefits. The Medicare supplemental insurer will automatically pay you if you accepted Medicare assignment. Otherwise, the member will be paid, and you will need to bill the member.

Claims Not Crossed Over
If the payment advice/EOMB does not indicate the claim was crossed over and you accepted Medicare assignment, file the claim as you do today. Blue Cross and Blue Shield of Oklahoma or the member’s Blue Plan will pay you the Medicare supplemental benefits. If you did not accept assignment, the member will be paid and you will need to bill the member.

When and how will I be paid for BlueCard claims?

Providers are paid on their Explanation of Claims Summary from Blue Cross and Blue Shield of Oklahoma. All terms of your Blue Cross and Blue Shield of Oklahoma agreement apply. Members are held harmless and cannot be balance billed. In some cases, a member’s Blue Plan may suspend a claim because medical review or additional information is necessary.

When resolution of claim suspensions requires additional information from you, Blue Cross and Blue Shield of Oklahoma may either ask you for the information or give the member’s Blue Plan permission to contact you directly. (Please refer to Appeals and Grievances Procedures section of this manual.)
BlueCard® Program — Section I

**Whom do I call about claims status, adjusting claims and resolving other issues?**

Call the Blue Cross and Blue Shield of Oklahoma Provider Inquiry Unit at 1-800-496-5774.

**How can I find out more information about the BlueCard program?**

Call the Provider Inquiry Unit phone number listed above or visit the Blue Cross and Blue Shield Association’s Web site at [www.bcbsok.com](http://www.bcbsok.com).

**How do I handle calls from members and others regarding claims status or payment?**

If a member contacts you, tell the member to contact their Blue Cross and Blue Shield Plan. Refer them to the front or back of their member ID card for a customer service number.
Administrative Services Only (ASO) — Section I

What is Administrative Services Only (ASO)?

ASO clients are employer groups who contract with Blue Cross and Blue Shield of Oklahoma for claims processing services, provider network access, clerical services or other administrative responsibilities that are a part of an employer group health benefit plan. Backed by the strength and stability of Blue Cross and Blue Shield of Oklahoma, our ASO accounts are provided the flexibility to meet the unique health benefit plan requirements of an employer group. Employer groups contract for the services that they need.

Administrative Services Only Network Utilization

Members may elect to participate in any of the Blue Cross and Blue Shield of Oklahoma networks or they may have ASO assigned networks. Please reference the member’s identification card for the appropriate customer service number to verify network affiliations and benefits.
Consumer Driven Health Plans — Section I

**Health Reimbursement Account**
Consumer driven health care plans (CDHP) combine a high deductible health plan with a health reimbursement account (HRA) and decision support tools. This combination allows members the freedom to choose their providers and the ability to spend their HRA in a manner that meets their needs. The use of the support tools encourages consumerism. The group is given the flexibility to mold its health plan in a manner that best suits its needs. Because of this, benefits will vary from group to group. It is best to always verify eligibility and benefits by calling the customer service phone number listed on the back of the member ID card.

<table>
<thead>
<tr>
<th>Network</th>
<th>BlueChoice</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General</strong></td>
<td></td>
</tr>
<tr>
<td>Benefit period deductibles (“Bridge”)</td>
<td>Ranges from $1000 to $4000 with single and family maximum</td>
</tr>
<tr>
<td>Individual and Family</td>
<td></td>
</tr>
<tr>
<td>Coinsurance</td>
<td>Varies by self-funded group</td>
</tr>
<tr>
<td><strong>Health Reimbursement Account (HRA)</strong></td>
<td></td>
</tr>
<tr>
<td>(Employer Funded)</td>
<td>Ranges from $750-$1250</td>
</tr>
<tr>
<td></td>
<td>Additional reimbursement for deductible may be payable to either member or provider depending upon plan. Additional reimbursement will be paid by a Third Party Administrator contracted by Blue Cross and Blue Shield of Oklahoma.</td>
</tr>
<tr>
<td><strong>Physician Services</strong></td>
<td></td>
</tr>
<tr>
<td>Subject to deductible and coinsurance</td>
<td></td>
</tr>
<tr>
<td><strong>Preventive care services</strong></td>
<td></td>
</tr>
<tr>
<td>If performed by a network provider may be covered. (Coverage varies by plan)</td>
<td></td>
</tr>
<tr>
<td>Adult routine physicals may be covered. (Coverage varies by plan)</td>
<td></td>
</tr>
<tr>
<td>Routine immunizations may be covered. (Coverage varied by plan)</td>
<td></td>
</tr>
<tr>
<td><strong>Mental Health services</strong></td>
<td>Benefits vary by group contract</td>
</tr>
<tr>
<td><strong>Hospital Services</strong></td>
<td>Subject to deductible and coinsurance</td>
</tr>
<tr>
<td><strong>Provider precert requirement</strong></td>
<td>All inpatient admissions and some outpatient services according to the BlueChoice provider contract.</td>
</tr>
</tbody>
</table>
Provider Inquiry Unit Department
Please call the toll free number listed on the back of member’s ID card for verification of eligibility, benefits and HRA funds and to check claim status

Member ID card

The company’s name and logo will appear on the front of the card.

Members utilizing the consumer driven health care plan with a health reimbursement account will have the text “health reimbursement account” on the front of the member ID card.

HRA paid to provider is followed by a P. HRA paid to subscriber is followed by an S.
Health Savings Accounts — HSA Blue

Health Savings Accounts (HSAs) combine a high deductible health plan with a health savings account and decision supports. This combination allows members the freedom to choose their providers and the ability to spend their HSA funds in a manner that meets their needs. The use of the support tools encourages consumerism. With a health savings account, members draw from their health savings account to cover medical expenses. Once the health savings account is exhausted, medical expenses are covered through a PPO plan. Because the amount of health savings accounts can vary by customer, it is best to always verify eligibility and benefits by calling the customer service phone number listed on the back of the member’s ID card.

<table>
<thead>
<tr>
<th>Network</th>
<th>BlueChoice</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General</strong></td>
<td></td>
</tr>
<tr>
<td>Deductibles:</td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$1,500, $2,000, $2,500, $3,000 or $5,000</td>
</tr>
<tr>
<td>Family</td>
<td>$3,000, $4,000, $5,000 $6,000 or $10,000</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>80% or 100% (for $5,000 single deductible and $10,000 family deductible only)</td>
</tr>
<tr>
<td><strong>Physician Services</strong></td>
<td></td>
</tr>
<tr>
<td>Annual Preventative Care</td>
<td>Subject to deductible and coinsurance</td>
</tr>
<tr>
<td></td>
<td>$300 benefit covered adult family member</td>
</tr>
<tr>
<td><strong>Mental Health services</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Subject to deductible and coinsurance</td>
</tr>
<tr>
<td><strong>Hospital Services</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Subject to deductible and coinsurance</td>
</tr>
<tr>
<td><strong>Provider precert requirement</strong></td>
<td>All inpatient admissions and some outpatient services according to the BlueChoice provider contract.</td>
</tr>
<tr>
<td><strong>Provider Inquiry Unit Department</strong></td>
<td>Please call the toll free number listed on the back of member’s ID card for verification of eligibility, benefits and HRA funds and to check claim status</td>
</tr>
</tbody>
</table>
BlueWorks Certified Workplace Medical Plan — Section I

Who is GHS Property and Casualty Insurance Company?

Established in 1993, GHS Property & Casualty Insurance Company (GHS P&C) is a subsidiary of Health Care Service Corporation of which Blue Cross and Blue Shield of Oklahoma is a division. GHS P&C is also a licensed third party administrator (TPA) with the ability to offer worker’s compensation claims processing and other worker’s compensation services.

BlueWorks: A certified workplace medical plan

What is BlueWorks?
BlueWorks is a network designed specifically for larger workers’ compensation and Occupational Accident self insured groups. GHS P&C provides claims processing capabilities, case management services, and access to the provider network of Blue Cross Blue Shield of Oklahoma. The largest clients include CompSource Oklahoma, Association of County Commissioners of Oklahoma, and John Christner Trucking.

BlueWorks network providers
The BlueWorks network is contracted separately from other Blue Cross Blue Shield of Oklahoma provider networks.

CompSource
CompSource is Oklahoma’s largest workers’ compensation insurance carrier. GHS P&C has contracted with CompSource to provide access to the BlueWorks network for workers’ compensation claimants who are receiving benefits through CompSource. When filing a claim for services rendered to someone covered by CompSource, file it directly with CompSource.

Identifying BlueWorks patients
When an employee covered by BlueWorks suffers from a work-related injury or illness within the course or scope of employment, he or she is required to immediately notify a designated coordinator. Either GHS Property and Casualty Insurance Company, the employer or CompSource will notify you of a patient covered by the BlueWorks Plan. Usually, the employee will have an authorization form indicating coverage through the BlueWorks Plan or CompSource.

In an emergency situation, the employee is instructed to seek immediate medical treatment. In this case, the employee may inform you of coverage by the BlueWorks plan. The employee or employer has 24 hours to report the work related injury or illness to us. You should receive a call on the employee confirming the patient is covered by BlueWorks or has used the BlueWorks network.

Billing
Once you have been notified that a patient is seeking treatment under the BlueWorks plan for a work-related injury or illness, send the bill to the location indicated on the authorization form, or contact BlueWorks at the number listed in the Quick Reference Section of this manual.
GHS Short-Term Health Plan

The Short-Term Health Plan is offered by GHS Property and Casualty Insurance Company, a subsidiary of Health Care Service Corporation of which Blue Cross and Blue Shield of Oklahoma is a division. It is a temporary health plan that provides coverage for members while their major medical health insurance applications are being processed. Coverage ranges from terms of 30, 60, 90, 120, 150 up to 180 days. For benefits and coverage information contact Provider Inquiry Unit at the number listed in the Quick Reference Section.
General Claim Information — Section I

General claim information

Participating providers shall submit all claims for payment for covered services performed for Blue Cross and Blue Shield of Oklahoma members utilizing claim forms identified in the Participating Provider Agreement and those listed in this manual. In addition to those instructions, participating providers shall adhere to the following policies with respect to filing claims for covered services to Blue Cross and Blue Shield of Oklahoma members:

1. A Provider performing covered services for a Blue Cross and Blue Shield of Oklahoma member shall be fully and completely responsible for all statements made on any claim form submitted to Blue Cross and Blue Shield of Oklahoma by or on behalf of the Provider. A Provider is responsible for the actions of staff members or agents.

2. Blue Cross and Blue Shield of Oklahoma considers fraudulent billing to include, but not be limited to the following:
   
i) deliberate misrepresentation of the services provided to receive payment for a noncovered service;
ii) deliberately billing in a manner which results in a reimbursement greater than what would have been received if the claim was properly filed; and/or
iii) billing for services which were not rendered.

3. Provider shall not bill or collect from a member, or from Blue Cross and Blue Shield of Oklahoma, charges itemized and distinguished from the professional services provided. Such charges include, but are not limited to, malpractice surcharges, overhead fees or facility fees, concierge fees or fees for completing claim forms or submitting additional information to Blue Cross and Blue Shield of Oklahoma.

4. A Provider is prohibited from paying or receiving a fee, rebate or any other consideration in return for referring a Blue Cross and Blue Shield of Oklahoma member to another provider or in return for furnishing services to a member referred to him or her.

5. Every Blue Cross and Blue Shield of Oklahoma member shall be supplied with an appropriate identification card and participating providers shall be entitled to require members to present their identification card when services are requested. It is recommended that photo identification be required each and every time services are provided.
6. Standard Blue Cross and Blue Shield of Oklahoma benefits are not available for services rendered by Providers to their immediate family members. Therefore, Blue Cross and Blue Shield of Oklahoma does not expect to receive claims for these services.

7. A Provider who refers a member to another provider who does not participate in the member’s PPO network, must disclose that fact to the member in writing and advise the member that they may incur higher deductibles or copayments and may be responsible for charges which exceed the allowable charges for network providers. Also, a provider who refers a member to a facility or other provider in which the referring physician has an ownership interest must disclose that interest in writing to the member.

Claim submission
The provider should submit properly filed claims for services using either the CMS-1500 or the UB-04 paper claims form and subsequent revisions, or submit claims electronically. All information necessary to adjudicate the claim, including appropriate ICD9-CM, CPT code or HCPC code must be provided.

Mailing addresses for claim processing

Federal Employee Program
Blue Cross and Blue Shield of Oklahoma
Federal Employee Program
P.O. Box 3492
Tulsa, OK 74101-3492

Administrative Services Only (ASO)
Administrative Services Only
P.O. Box 3028
Tulsa, OK 74101-3028

BlueLincs HMO
BlueLincs HMO
P.O. Box 21128
Tulsa, OK 74121-1128

Blue Cross and Blue Shield of Oklahoma
Blue Cross and Blue Shield of Oklahoma
P.O. Box 3283
Tulsa, OK 74102-3283

Information about the Health Insurance Accountability and Portability Act (HIPAA) is available at www.bcbsok.com. Simply follow the provider link at the top of the page for information about transactions and code sets and becoming a trading partner.
General Claim Information — Section I

Timeliness
Claims will not be payable if they are not filed within the time frame indicated in your Participating Provider agreement. Blue Cross and Blue Shield of Oklahoma is obligated to process clean claims for covered services within 30 days of the date the clean claim is received.

Right to offset
Blue Cross and Blue Shield of Oklahoma contractually has the right to offset. This right allows us to retract overpayment amounts from your future payments. We will notify you of any offset amounts, the name of the patient for whom an overpayment was made in error and the relevant dates of service. This information is noted on the Explanation of Claims Summary sent with every check issued by Blue Cross and Blue Shield of Oklahoma. (Refunding the patients or Blue Cross and Blue Shield of Oklahoma without prior notification could result in an incorrect adjustment to your claim.)

- For lines of business that are converted to our new claims system, you will receive a letter requesting a refund. Providers will be given 30 days to submit the refund, prior to an automatic retraction occurring.
  - A Remittance Form will be provided as well as a return envelope to submit the refund.
- For lines of business that still reside on the old claims system, automatic retractions will occur until those lines of business are fully converted.
- Once all lines of business are fully converted, a refund request will be sent. If you prefer to have the automatic retraction, no action is required.

Claim submission resources
This section is not an endorsement of any listed company or organization. It is only intended to serve as a resource list for your office staff:

1. If you need information regarding the completion of the UB-04 form, or subsequent versions of this form, access the Web site www.nubc.org.

2. If you need information regarding the completion of a CMS-1500 form, visit www.bcbsok.com/form which includes instructions for completing the CMS-1500.

3. If you have questions about submitting claims electronically through Blue Cross and Blue Shield of Oklahoma Provider Automated Claims Transmission (PACT) system, please call our Electronic Commerce division at 1-800-722-3218.

4. If you need technical specifications for filing electronically with Blue Cross and Blue Shield of Oklahoma, please call our network services help line at 1-800-722-3218 or access the website at www.bcbsok.com.

5. To view the list of Blue Cross and Blue Shield of Oklahoma Medical Policies and other information access our website at www.bcbsok.com and select “Providers.”
Availity Web Portal – Section I

What is Availity, LLC.?
Availity, LLC., offers the new online service/Web portal for Blue Cross and Blue Shield of Oklahoma health care providers. Availity is jointly owned by Blue Cross and Blue Shield of Florida, Humana and Health Care Service Corporation, which operates through its Divisions: Blue Cross Blue Shield of Illinois, Blue Cross and Blue Shield of New Mexico, Blue Cross and Blue Shield of Texas, and Blue Cross and Blue Shield of Oklahoma. Availity is a leading provider of electronic health care transactions and will provide health care professional access to a wide range of Web-based products and services.

What is the Availity Web Portal?
The Availity Health Information Network is a secure, Web-based, full service information exchange that offers a claims clearinghouse and real-time transactions at no charge to our providers. Transactions include eligibility and benefits, claim status, claims submission, electronic remittance and authorizations and referrals. The portal encompasses administrative, financial, and clinical services, supports both real-time and batch transaction and is HIPAA compliant.

How do I enroll/sign up with Availity?
To sign up or get more information go to www.availity.com.
Updating Payment and Practice Information — Section I

Updating payment and practice information

Blue Cross and Blue Shield of Oklahoma
To update our records, please submit a written request to Health Industry Relations. Providers may use the Practice Change Information form in this manual. Fax the request to Health Industry Relations (918) 551-3413, or mail the request to the following address:

Blue Cross and Blue Shield of Oklahoma
Health Industry Relations
PO Box 3283
Tulsa, OK 74102

Medicare Part A Intermediary
To update your facility payment information for Medicare Part A Intermediary claims submitted to Blue Cross and Blue Shield of Oklahoma, please send written notification to the Assistant Manager, Medicare Reimbursement:

Blue Cross and Blue Shield of Oklahoma
Medicare Part A Intermediary
PO Box 3404
Tulsa, OK 74101-3404
FAX: (918) 551-2303

If you have any questions about reimbursement or payment changes, please call (918) 551-2236.

IMPORTANT NOTE: Please note that submitting a claim with updated information is not a valid notice of a change in the provider’s practice location and payment information. Records are not updated according to submitted claim information.
# Sample CMS-1500 — Section I

## Health Insurance Claim Form

### Approved by National Uniform Claim Committee (05/05)

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
<td>Patient's Name (Last Name, First Name, Middle Initial)</td>
</tr>
<tr>
<td>3.</td>
<td>Patient's Date of Birth (MM DD YY)</td>
</tr>
<tr>
<td>5.</td>
<td>Patient Relationship to Insured</td>
</tr>
<tr>
<td>6.</td>
<td>Patient Status</td>
</tr>
<tr>
<td>9.</td>
<td>Other Insured's Name (Last Name, First Name, Middle Initial)</td>
</tr>
<tr>
<td>10.</td>
<td>Insured's Condition Related To</td>
</tr>
<tr>
<td>11.</td>
<td>Insured's Policy Group or PEPAC Number</td>
</tr>
<tr>
<td>12.</td>
<td>Is There Another Health Benefit Plan?</td>
</tr>
<tr>
<td>13.</td>
<td>Date of Current Illness (First Symptoms) or Injury (Accident or Pregnancy)</td>
</tr>
<tr>
<td>14.</td>
<td>Dates Patient Unable to Work in Current Occupation</td>
</tr>
<tr>
<td>15.</td>
<td>Dates Hospitalization Dates Related to Current Services</td>
</tr>
<tr>
<td>16.</td>
<td>Diagnosis or Nature of Illness or Injury (Relate Items 1, 2, 3 or 4 to Item 24 by Line)</td>
</tr>
<tr>
<td>17.</td>
<td>Place of Service (Specifyif Other Than Hospital)</td>
</tr>
<tr>
<td>18.</td>
<td>Physician or Supplier Information</td>
</tr>
</tbody>
</table>

**Notes:**
- **Signed and Date:** Required fields.
- **NPI:** National Provider Identifier.
- **CMS-1500 Instructions Manual Available at: www.nucc.org**

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**Blue Cross and Blue Shield of Oklahoma Provider BluePrint Manual (05/08)**

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How to Complete the CMS-1500 — Section I

Summary

This section contains a sample CMS-1500 Health Insurance Claim Form with instructions for each box or field. In general, these instructions apply to both paper and electronic claim filing. The following symbols are used to indicate useful tips that can significantly reduce processing delays:

- Indicates a valuable tip regarding both paper and electronic claim filing.
- Indicates information specific to electronic claim filing.
- Indicates information specific to paper claim filing.

General instructions

- Please complete all boxes/fields.
- Use “N/A” to indicate a box or field that is not applicable to the claim.
- Use precise AMA CPT procedural codes or HCPC codes for faster and more accurate payments. To order the AMA CPT code book, call the AMA toll free at 1-800-621-8335.
- Do not use “Not Otherwise Classified” codes (NOC codes). Claims with NOC codes are returned for more information.
- We stress the importance of accuracy and attention to every detail. Inconsistency or lack of information could delay your payment.

Explanation of line items

The primary source for these instructions is the Health Insurance Carrier Directory (A Comprehensive Guide to Insurance Carriers & Claims Processing) published by Practice Management Information Corporation (PMIC). You can order this publication by calling PMIC toll free at 1-800-633-4215. This information can be obtained by other commercial vendors as well.
What is a Provider Claims Summary?

A Explanation of Claims Summary is an explanation of claims submission. You can use the Explanation of Claims Summary to determine how a claim was processed, including non-allowed amounts or adjustments. The Explanation of Claims Summary will note any appropriate deductible and coinsurance amounts that are the responsibility of the member, in addition to any non-allowed amounts that are the responsibility of the member or the provider.

The Explanation of Claims Summary also indicates the correct customer service phone number to call with questions regarding a particular claim. The first page of the Explanation of Claims Summary lists and explains all codes used in processing each claim in the report. If claim reports are separated for billing or accounting purposes, it is important to make sure every associate receives a copy of the first page(s) which lists and describes all codes contained in the report.

The following pages provide a sample Explanation of Claims Summary for your reference.
Example BCBSOK Explanation of Claims Summary

PROVIDER CLAIM SUMMARY

DATE: 06/26/97
PROVIDER #: 20946097
CHRY: 20946097
TAX IDENTIFICATION #: 09460427

P.O. Box 3213
3211 S. Boulder
Tulsa, Oklahoma 74135-3213
1-800-469-7744

Any messages will begin on page 1.

PATIENT: 30-5000
PEFF PROV: 20946097
ID: 39345
TAX ID: 09460427
CLAIM NO: 06007860000000

FROM TO DATES: 06/07-06/07 01 001
PROC PB: 559.00
BILLED AMOUNT: 237.25
ALLOWABLE SERVICES: 297.22
DEDUCTION/OTHER AMOUNT: 0.00
INELIGIBLE PAID: 237.23

TOTAL SERVICES NOT COVERED: 297.77
PATIENT'S SHARE: 40.40

NUMBER OF CLAIMS: 1
AMOUNT PAID TO SUBSCRIBER: 60.00

AMOUNT BILLED: 4535.00
AMOUNT PAID TO PROVIDER: 237.25
AMOUNT OVER MAXIMUM ALLOWANCE: 297.77
RECAPTURE AMOUNT: 40.40
AMOUNT OF SERVICES NOT COVERED: 297.77
NET AMOUNT PAID TO PROVIDER: 237.25
AMOUNT PREVIOUSLY PAID: 0.00

PLACE OF SERVICE (PS) TYPE OF SERVICE (TS)
01 HOSPITAL INPATIENT. 001. SURGERY

CLAIM TYPE
000... BLUE CHOICE

MESSAGES:
(1) Submitted charge(s) exceeds the priceds amount for this service.
Services provided by a participating network provider. Patient is not responsible for charges over the priceds amount.
**BCBSOK Sample Explanation of Claims Summary - Section I**

---

**PROVIDER CLAIM SUMMARY**

<table>
<thead>
<tr>
<th>DATE</th>
<th>06/21/07</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROVIDER NUMBER</td>
<td>129466760-000</td>
</tr>
<tr>
<td>CHECK NUMBER</td>
<td>12945070</td>
</tr>
<tr>
<td>TAX IDENTIFICATION NUMBER</td>
<td>8870054321</td>
</tr>
</tbody>
</table>

**ANY MESSAGES WILL BEGIN ON PAGE 1**

---

**DISTRESS OVER 65 OUT-PATIENT**

<table>
<thead>
<tr>
<th>PATIENT</th>
<th>ABONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLAIM NO</td>
<td>000671872227229C</td>
</tr>
<tr>
<td>CLAIM TYPE</td>
<td>T</td>
</tr>
<tr>
<td>HPI</td>
<td>A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DAYS</th>
<th>APG</th>
<th>PROVIDER</th>
<th>OTHER PAYABLE</th>
<th>FACILITY</th>
<th>ADJUSTED</th>
<th>MANAGED CARE</th>
<th>TOTAL AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>001</td>
<td>1,722.00</td>
<td>40.00</td>
<td>$1,572.23</td>
<td>$1,722.00</td>
<td>40.00</td>
<td>$130.00</td>
<td></td>
</tr>
</tbody>
</table>

**MESSAGES/REASONS:**

- (408). Payment cannot exceed the allowable charge determined by Medicare.

---

**CLAIM TYPE**

- T - BLUE TRADITIONAL

---

**MESSAGES/REASONS:**

- (408). The member/patient may have health coverage through another carrier/Medicare. Expenses may be eligible for payment by that carrier.

---

**PROVIDER CLAIMS AMOUNT SUMMARY**

<table>
<thead>
<tr>
<th>NUMBER OF CLAIMS</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROVIDER CHARGES</td>
<td>$1,722.00</td>
</tr>
<tr>
<td>ADJUSTED PROVIDER CHARGES</td>
<td>$1,722.00</td>
</tr>
<tr>
<td>PATIENT'S SHARE</td>
<td>$40.00</td>
</tr>
</tbody>
</table>

| AMOUNT PAID | $130.00 |
| RECOUPMENT AMOUNT | $40.00 |
| NET AMOUNT PAID | $130.00 |
Common Message and/or Reason Codes — Section I

Common Message and/or Reason Codes

If, for any reason, an amount is not allowed when processing your claim, the non-allowed code and description will appear on your Explanation of Claims Summary. The Explanation of Claims Summary accompanies every check issued by Blue Cross and Blue Shield of Oklahoma. The first page of the Explanation of Claims Summary will list and describe all non-allowed codes applied to the processed claims contained in the Explanation of Claims Summary report. For each claim, any applicable message and/or reason codes will be listed in the Explanation of Claims Summary.
What is a Claim Pricing Detail Report

The Explanation of Claims Summary, a Claim Pricing Detail Report is available at www.availity.com. The report summarizes your outpatient claims, line by line. It will provide you with additional APG payment information to validate your reimbursement.

The following is a sample Claim Pricing Detail Report and an explanation of each information field.

Sample Claim Pricing Detail Report

![Sample Claim Pricing Detail Report Image]
How to Check Claim Status — Section I

How to check claims status

There are two ways to check the status of a claim:

1. The free, secure provider page on the Blue Cross and Blue Shield of Oklahoma Web site. Visit www.availity.com and follow the provider link at the top of the page for more information.

2. Call the appropriate Provider Inquiry Unit department listed on the member’s ID card. If you do not have immediate access to the member’s card, a list of phone numbers can be found in the Quick Reference Section.

How to avoid common claims processing delays

1. Always enter your name and complete NPI in Box 51 of the UB-04 or Box 33 of the CMS-1500 and subsequent revision of these forms. Please do not stamp your number in red ink.

2. Do not submit duplicate claims. Use the secure provider site at www.bcbsok.com or call the appropriate Provider Inquiry Unit phone number to check the status of a current claim. Claims examiners are required to review every submitted claim in its entirety — even duplicates. (Provider Inquiry Unit phone numbers are listed in the Quick Reference Section)

3. If you need to submit a corrected claim, please circle each specific correction on the claim. Corrected claims must be sent on paper with the words “corrected claim” noted on the claim.

4. For the CMS 1500 use box #9-9d of the claim form if the patient is covered by a second health benefit plan. Do not use this area to submit additional patient information unrelated to a second health benefit.

5. If you enter a date in box #14 of the form, please specify if the date applies to the first symptom, injury date or last menstrual period. This information must be consistent with the information provided in box #24.

6. Incorrect or inaccurate diagnosis pointing will delay your claim payment. For more information, refer to the sample CMS 1500 claim form contained in this manual and to the completion instructions for box #24e.
7. For Professional and Ambulatory Surgery Center claims, please complete boxes 32 and 33 of the CMS 1500. Incorrect or incomplete information has a significant impact on claim processing time.

8. Please include the member’s entire Blue Cross and Blue Shield of Oklahoma ID number, including alpha-prefix.
How to Avoid Common Claims Processing Delays — Section I

Claims will be returned if information is invalid, incomplete or missing, including, but not limited to:

- procedure code
- diagnosis code
- patient date of birth
- place of service code
- National Provider Identifier (NPI)

1. Please ensure there are no zero charges for any services and that the total charge is included and equals the sum for the individual charges.

2. Please include the Medicare explanation of benefits when Medicare is the primary payor or other carrier explanation of benefits when coordination of benefits is required.

3. Submit all claims on the red CMS-1500 form.

4. When submitting J codes for drug injection or an unclassified procedure code, please include a description drug name or description of the item.

5. When billing for an administration fee please include the description of the medication administered.

*Note:* When filing electronically using the CMS 1500, you can only assign one diagnosis code for each procedure code due to field limitations.
Member Rights and Responsibilities — Section I

Complaint and grievance procedure

The excerpt is from the BlueChoice PPO benefit book — members with other health plans may have different appeal procedures. Check with customer service.

SPECIAL NOTICE REGARDING COMPLAINT/APPEAL PROCEDURE

Effective October 15, 2006 (or your Effective Date, if later), your Certificate (Benefit Booklet) is amended as set forth below:

Your Certificate is amended so that the Claim/Grievance Procedures or Complaint/Appeal Procedures currently reflected in your Certificate, or in any amendment attached thereto, are hereby deleted and restated as follows:

COMPLAINT/APPEAL PROCEDURE

Blue Cross and Blue Shield of Oklahoma has established the following process to review your dissatisfactions, complaints and/or appeals. If you have designated an authorized representative, that person may act on your behalf in the appeal process. *

If you have a question or complaint, an initial attempt should be made to resolve the problem by directly communicating with a Blue Cross and Blue Shield of Oklahoma Customer Service Representative. In most cases, a Customer Service Representative will be able to provide you with a satisfactory solution to your problem. However, if a resolution cannot be reached in an informal exchange, you may request an administrative review of the problem through our appeal process described below.

You may request to review information used to make any adverse determination. Copies will be provided free of charge.

- **APPEAL PROCESS (Level I)**

  If you are not satisfied with the initial attempt to resolve the problem, or if you wish to request a review of a Benefit determination or Precertification decision, you must request an appeal within 180 days from the date you received notice of the adverse Benefit determination or Precertification notice. A Provider can also appeal the adverse Benefit determination or Precertification decision. The Provider's appeal will be considered an appeal on your behalf.

  - **How to File an Appeal Involving a Non-Urgent Request or Claim**

    In the case of an appeal involving a non-urgent request or claim, you must submit the request in writing to the following address:

    Appeal Coordinator – Customer Service Department
    Blue Cross and Blue Shield of Oklahoma
    P. O. Box 3283
    Tulsa, Oklahoma 74102-3283

    The written request should include the name of the Subscriber, the Subscriber identification number, the nature of the complaint, the facts upon which the complaint is based, and the resolution you are seeking. Necessary facts are: dates and places of services, names of Providers of services, place of hospitalization and types of services or procedures received (if applicable). You and/or your Provider should include any documentation, including medical

*The Plan has established procedures for you to designate an individual to act on your behalf with respect to a Benefit claim or an appeal of an adverse Benefit determination. A Provider or other health care professional with knowledge of your medical condition is permitted to act as your authorized representative or bring an appeal on your behalf.
records, that you want to become a part of the review file. The Plan may request further information if necessary.

" In the case of an appeal involving a non-urgent Precertification request, the Plan will provide a written response to you no later than 30 days following the date the appeal is received.

" In the case of an appeal involving a claim other than a Precertification request, the Plan will provide a written response to you no later than 60 days following the date the appeal is received.

- How to File an Appeal of a Precertification Request Involving Urgent Care

If you and/or your Provider wish to appeal a Precertification Request Involving Urgent Care, you may appeal by calling the Precertification number shown on your Identification Card.

" The Plan will respond to you no later than 72 hours after the appeal request is received.

" The Plan’s response to a Precertification Request Involving Urgent Care, including an adverse determination, if applicable, may be issued orally. A written notice will also be provided within three days following the oral notification.

• VOLUNTARY RE-REVIEW PROCESS (Level II)

If you are not satisfied with the decision concerning the appeal, you may elect to submit the adverse Benefit determination to the Plan for re-review. The Plan will provide you with information about the Plan’s voluntary re-review process.

To request a re-review of the Benefit determination, you should submit the request in writing to the following address:

Appeal Coordinator – Customer Service Department
Blue Cross and Blue Shield of Oklahoma
P. O. Box 3283
Tulsa, Oklahoma 74102-3283

The written request should include the name of the Subscriber, the Subscriber identification number, the nature of the complaint, the facts upon which the complaint is based, and the resolution you are seeking. Necessary facts are: dates and places of services, names of Providers of services, place of hospitalization and types of services or procedures received (if applicable). You should include any documentation, including medical records, that you want to become a part of the review file. The Plan may request further information if necessary.

A Precertification Request Involving Urgent Care may be re-reviewed by calling the Precertification number shown on the Identification Card.

! EXTERNAL REVIEW (Level III)

For services that are denied as not Medically Necessary, medically appropriate, or medically effective, Oklahoma law provides the right to an external review by an independent review organization. If requested, the Plan will notify you, in writing, of the procedure to obtain an external review as set forth in the Oklahoma Managed Care Review Act.

You are not obligated by the Group Health Plan to pursue the Plan's voluntary re-review process or an external review in any specific order. You are not required to exhaust the voluntary re-review process before bringing a civil action. If the review processes do not provide a satisfactory resolution to the claim for Benefits, legal remedies are available, including pursuing the claim in court.
*****

Except as amended, your Certificate/Booklet remains unchanged.

PLEASE KEEP THIS NOTICE WITH YOUR CERTIFICATE/ BOOKLET FOR FUTURE REFERENCE.
Quick Reference — Section I

How to verify membership and benefit eligibility or check claim status

Member benefits are subject to the member contract limitations and exclusions. To verify benefit coverage, call the appropriate Provider Inquiry Unit number. You will need the following information to verify coverage:

- Member name
- Member ID number
- Member date of birth
- National Provider Identifier (NPI) number

Blue Cross and Blue Shield of Oklahoma
Provider Inquiry Unit
Statewide
Online benefits and eligibility
Hours: 8 a.m. to 5 p.m., Monday through Friday
1-800-496-5774
www.availity.com

Precertification/request for out-of-network authorization
Statewide
Fax
1-800-672-2378
1-800-220-4045

In-Network Referral Authorization
Statewide
Fax
1-800-241-2583
1-800-220-4045

Health Promotions
(Disease Management)
1-800-388-4673

BlueCard Eligibility and Benefits
Non-Oklahoma members
Provider Inquiry Unit
1-800-676-2583
1-800-496-5774

BlueLincs HMO
Statewide
Precertification/Authorization
For out of state members
Magellan Behavioral Health
Hours: 8 a.m. to 5 p.m., Monday through Friday
1-800-580-6202
1-800-580-4454
1-800-676-2583
1-877-794-0678
Quick Reference — Section I

**Administrative Services Only**

Statewide  
1-800-672-2567

In-network referral authorization  
1-800-241-2583

Precertification/authorization  
1-800-672-2378

Hours: 8 a.m. to 5 p.m., Monday through Friday

**Note:** Please verify customer service numbers on the back of each member’s cards as some numbers may vary.

**BlueWorks**  
1-888-290-2583

**Federal Employee Program**  
1-800-722-3130

Magellan Behavioral Health  
1-877-906-6389

**Plan65**

Membership and eligibility  
1-800-496-5774

Claims status  
1-800-722-3959

**The Medicare Intermediary Program**  
Hours: 8 a.m. to 4 p.m., Monday through Friday

Claims processing or general inquiries where Medicare is the primary payer  
1-877-567-3094

Medicare Provider Enrollment  
Hours: 9 a.m. to 4 p.m., Monday through Friday  
1-866-277-1655 (Option 2)

Available workshops and training sessions (including PACT)  
(918) 551-2525

Medicare reimbursement and/or notice of payment changes (such as tax ID)  
(918) 551-2236

Medicare Audit  
(405) 316-7151

Fax  
(918) 551-2303

Website:  
www.chisholmadmin.com

PACT Technical Inquiries  
1-800-722-3218 (Option 3)

Oklahoma City  
(405) 841-9799

Tulsa  
(918) 551-3399

Statewide  
1-800-722-3959
Quick Reference — Section I

**Provider Fraud Hotline:** 1-877-272-9741  
The Fraud Hotline operates 24 hours per day, seven days per week.  
Suspicious of fraud may be reported anonymously.

**Web site reporting:** [www.bcbsok.com/sid/reporting](http://www.bcbsok.com/sid/reporting)  
The web site address links to an online fraud reporting form that can be completed and sent to the Special Investigations Department (SID) electronically.

**U. S. Mail**

Blue Cross and Blue Shield of Oklahoma  
Special Investigations Department  
P.O. Box 3283  
Tulsa, OK 74102-3283

Additional information about the SID and a free fraud awareness training program are available at [www.bcbsok.com/sid](http://www.bcbsok.com/sid)

**Oklahoma Bureau of Narcotics** 1-800-522-8031  
Prescription Monitoring Program (PMP)

To Access: go to OBN's website at [www.ok.gov/obndd](http://www.ok.gov/obndd)

   Click on Prescription Monitoring Program (PMP) located at the bottom of the page  
   Scroll to the bottom and click at the point where you are instructed to "* To Request Access to PMP, click here" and follow the instructions for submission.

Data available through the PMP:

- Name
- Date of Birth
- Address of patients filling controlled drug prescriptions
- Date
- Type of controlled drug prescription
- Quantity
- Prescription number and Prescriber information
Quick Reference — Section I

Health Industry Relations – East

Provider Relations Representatives
Hospital - Pam Milleson (918) 551-3357
Ancillary - Suzie Omstead (918) 551-3551

Manager (Physician and Health Care Professionals)
Regina Brown (918) 551-3327

Professional Provider Relations Representatives
Jeanne Booth (918) 551-3524
Andrea Wooldridge (918) 551-3538
April Bowman (918) 551-3537
Janet Crawford (918) 551-3170

Provider Inquiry Specialist (claims)
Rosalyn Benjamin (918) 551-3650
Joanne Criner (918) 551-3650

Health Industry Relations East - Fax (918) 551-3413
Quick Reference — Section I

Health Industry Relations – West

Provider Relations Representatives
   Hospital – Angela Qualls (405) 316-7078
   Ancillary – Jan Poe (405) 316-7179

Manager (Physician and Health Care Professionals)
   Laura Hottel (405) 316-7020

Professional Provider Relations Representatives
   Kari Govier-Brown (405) 316-7187
   Roxie Coburn (405) 316-7188
   Cindy Luckens (405) 316-7181
   Kathy Medford (405) 316-7017

Provider Inquiry Specialist (claims)
   Renae Applegate (405) 841-9773
   Deborah Chastain (405) 841-9773

Health Industry Relations West - Fax (405) 316-7134
Quick Reference — Section I

**Precertification is required for the following services**

All inpatient admissions and certain outpatient services performed in an ambulatory surgical center require precertification. Emergency and obstetric admissions require certification within 48 hours of the actual admission or certain ancillary service.

**Exceptions:**

- Precertification is only required for BlueTraditional members if it is required in their benefit agreement.
- Precertification is only required for Blue Plan65 Select members if Medicare Part A benefits have been exhausted.

If precertification is required, the back of the member ID card will list a precertification phone number.

**How to request precertification**

1. First, verify membership and benefit coverage. Call the appropriate Provider Inquiry Unit number listed on the member’s ID card. After verification, the Provider Inquiry Unit can transfer your call to the Precertification Department.

2. If you wish, call the Precertification Department directly using the number in the quick reference list. The department handles precertification requests for both Blue Cross and Blue Shield of Oklahoma and Administrative Services Only (ASO) members.

3. Please have the following clinical information available:
   - Admitting physician’s name, address and telephone number.
   - Patient’s name, address, age, sex and birthdate.
   - Subscriber’s name and address if different from the patient.
   - Subscriber’s group number or employer name if the group number is not available.
   - Subscriber’s Blue Cross and Blue Shield ID number.
   - Hospital to which the patient is to be admitted.
   - Estimated date of admission and discharge.
   - Primary diagnosis (ICD-9 code, if known).
   - Proposed procedure(s) (AMA CPT or ICD-9 codes, if known).
   - Patient’s history, lab and test results pertinent to this hospitalization/procedure.
   - Precertification should be obtained at least five (5) days in advance, if possible. Precertification must always be obtained prior to the actual admission and/or services rendered.
   - Admission certification must be obtained within 48 hours after an emergency or obstetric admission.
   - Recertification must be obtained on or before the last day of the Blue Cross and Blue Shield of Oklahoma assigned length of stay.

The recertification process is the same as the precertification process.
Quick Reference — Section I

**When is in-network referral authorization required?**

A member who subscribes to a plan with a designated PCP requires in-network referral authorization from the PCP for the following services:

- Any service the PCP does not provide or bill, including lab and x-ray services.
- Referrals to specialists.
- Referrals to hospital outpatient departments.
- All hospital inpatient admissions.

**Identification of members who require in-network referrals**

Check the member ID card.

- If the member subscribes to BlueChoice or BluePreferred with a PCP, the front of the ID card will indicate the designated PCP’s name.
- Members of Custom Group Services who require in-network referrals will have referral instructions on the back of the member ID card.

**When is out-of-network referral authorization required?**

In the event that a member needs medically necessary services unavailable within his or her network, the treating physician should call the Blue Cross and Blue Shield of Oklahoma to request authorization for an out-of-network referral. This requirement does not apply to members with BlueTraditional benefits.

**Remember**

- Referrals must be authorized prior to the date of service.
- If a member insists on a referral that you believe is inappropriate, you are not obligated to authorize the referral. Advise him or her to call the appropriate customer service phone number.
- Precertification is a separate process. Precertify medical service as required. Refer to “Quick Reference: Precertification” for details.
Quick Reference — Section I

How to authorize an in-network referral

Call the appropriate referral number listed in the beginning of this section.

You will need to provide the following information:

- The PCP’s 4-digit ID number and 4-digit security code.
- The member’s ID number.
- The referral number of the specialist or facility.
- The reason for the referral and the ICD-9 codes.
- The authorized treatment plan including beginning and ending dates of service.

We will assign a referral confirmation number over the phone. You are contractually obligated to provide the confirmation number and authorized treatment plan to the specialist or facility. If you prefer to fax a referral authorization for Blue Cross and Blue Shield of Oklahoma members, you can fax the appropriate form to the number listed.

How to extend an in-network referral

- Call the appropriate phone number listed on the previous pages. You also may fax a request for an extension.
- You will be required to provide additional clinical information to justify an extension.

How to request authorization for an out-of-network referral

- For Blue Cross and Blue Shield of Oklahoma and Administrative Service Only (ASO) members, call the precertification department.
- When requesting authorization for an out-of-network referral. Medical information will be required to justify a referral.
Quality Improvement Committees — Section I

The Quality Improvement Committee (QIC) is responsible for the implementation and oversight of the Quality Improvement Program including the review and approval of the Quality Improvement plan, annual Quality work plan and annual program evaluation. This committee is accountable for and provides oversight for all Quality Improvement activities, ad hoc committees and all subcommittee activities. The QIC subcommittees include Clinical Services, Credentialing, Utilization Management, Case Management, Peer Review, Peer Review subcommittees, Member Rights and Responsibilities, Pharmacy and Therapeutics Advisory, Disease Management/Wellness and Member Participation and Protection.

Clinical Services Committee
This committee is responsible for the development and implementation of processes and procedures related to the measurement and evaluation of the quality of clinical care, service and identifying areas for improvement including: the development of preventive health guidelines, review and approval of all clinical practice guidelines, standards of care and appropriateness of care review criteria, the review and evaluation of practitioner performance data and practitioner surveys, and development of QI studies and quality improvement data collection and reporting.

Credentialing Committee
This committee is responsible for initial credentialing, recredentialing and appeals of providers and facilities, and for the annual review of credentialing/recredentialing policies and procedures, with revisions occurring as necessary. The committee has primary responsibility for developing and implementing credentialing and recredentialing policies and procedures for all network practitioner(s) (both individual and institutional). Additionally, the committee is responsible for integrating quality improvement, utilization management and member complaint/grievance data that meets minimum necessary privacy requirements and information into the recredentialing process, as well as making recommendations regarding corrective actions and practitioner status, based on information collected through performance monitoring and quality improvement activities.

Utilization Management Committee
The UM Committee is responsible for the review and approval of the Utilization Management Plan and policy and procedures, defining processes and mechanisms for monitoring and managing utilization of services and resources. Additionally, responsibilities include:

- Monitoring and evaluating delegated UM activities.
- Developing and monitoring performance standards.
- Monitoring and responding to over- and under-utilization, and utilization management data collection and reporting.
Quality Improvement Committees — Section I

**Peer Review Committee (East and West)**
These committee are responsible for monitoring and evaluating quality of care and the overall performance of practitioners, handling first and second level network participation provider appeals for denials, disputes, complaints and grievances, formulating corrective actions for improving identified deficiencies and providing feedback to individual practitioners. The committee can make recommendations for cases/charts under review to be referred to the Peer Review subcommittee for further investigation and /or recommendations.

**Member Participation and Protection Committee**
The Member Participation and Protection Committee is responsible for the development and implementation of processes and procedures for monitoring and evaluating the quality of services provided to members. The committee meets monthly, is chaired by the manager, member advocacy, and reports to QIC. MPPC activities and responsibilities include:

- Implementing and monitoring mechanisms for member complaints, grievances and appeals
- Monitoring and evaluating member satisfaction.
- Conducting reviews and providing decisions in regard to member level 2 appeals within HIPAA guidelines.
- Communicating with and educating members.
- Monitoring compliance with standards for practitioner access.
- Preparing quarterly and annual reports for QIC.

**Case Management Committee**
The committee is responsible for implementing and monitoring the Case Management program and activities, as well as recommending actions for improving the delivery and utilization of health care resources. Additional responsibilities include:

- Annual review and approval of the Case Management Plan, URAC accreditation standards and departmental policies and procedures.
- Defining processes and mechanisms for monitoring and managing utilization of services and resources.
- Monitoring and evaluating specific Case Management activities.
- Developing and monitoring performance standards.
- Reviewing Case Management surveys and making recommendations.
- Documenting all quality management actions and activities, reviewing all QA/QI referrals and forwarding quarterly reports to the QIC and receiving feedback from QA/QI regarding quality issues.
Quality Improvement Committees — Section I

Pharmacy and Therapeutics Advisory Committee
The committee is responsible for the review of existing formulary contents as well as review of new medications being approved by the FDA, patent safety initiatives, clinical aspects of medications, comparisons of medications, outcomes of studies and utilization of medications. Additional responsibilities include:

- Reviewing medications for safety, efficiency, uniqueness and value.
- Reviewing pre-certifications and appeals on various medications to assure appropriate and safe use of medications.

Disease Management/Wellness Committee
The committee is responsible for the guidance and direction of both the internal and delegated external activities. The committee establishes, develops, monitors and assesses all activities and outcomes. Additional responsibilities include:

- Development of program goals for interventions, activities and outcomes.
- Establishment of target dates for program goals and assignment of staff accountability.
- Evaluation of the effectiveness of “the programs” outcomes and activities.

Member Rights and Responsibilities Committee
This committee is responsible for the development and implementation of processes and procedures for monitoring and evaluating the quality of services provided to members. The committee meets quarterly. Additionally, a Member Compliant Workgroup meets monthly to review all member complaints received by the Member Services Department. The committee is responsible for implementing and monitoring mechanisms for member complaints and grievance resolution, member communication and education, monitoring and evaluating member satisfaction and establishing monitoring compliance with standards for practitioner access.
Disease Management — Section I

What is Disease Management?

Health Promotion is a free and voluntary program designed to educate and empower members with chronic conditions. Members work with a nurse case manager and their physician to control the symptoms of their condition. There are currently five programs in place:

- Diabetes
- Congestive Heart Failure (CHF)
- Asthma
- Coronary Artery Disease (CAD)
- Chronic Obstructive Pulmonary Disease (COPD)

The program relies heavily on education, providing members the tools to make healthy lifestyle choices. The types of education include:

- Printed booklets and brochures
- Follow-up materials mailed regularly
- Classes, specific to medical condition, conducted by certified instructors (where available)
- Phone support with the nurse case manager

Blue Cross and Blue Shield of Oklahoma also supplies free equipment to members to monitor certain conditions managed in the disease management programs. The diabetes program offers a free glucose meter; the asthma program offers a free peak flow meter; the CAD programs offers a pedometer to encourage exercise; and the CHF program offers a free scale so the member may monitor his/her weight on a daily basis.

For more information, or to enroll a member in one of the free disease management programs, contact the nurse case manager listed here.

For the Diabetes Program, contact the diabetes nurse care manager toll-free at 1-800-670-6681.

For the CHF Program, contact the nurse care manager toll-free at 1-866-670-6681.

For the CAD Program, contact the nurse care manager toll-free at 1-866-670-6681.

For the Asthma Program, contact the nurse care manager toll-free at 1-877-715-7840.

For the COPD Program, contact the nurse care manager toll-free at 1-866-670-6681.
Preventive Healthcare services are those that would be performed for otherwise healthy, asymptomatic people, with the intent of reducing future adverse outcomes. Preventive services include prophylactic interventions (such as immunizations), as well as screening tests, which seek to improve outcomes through early diagnosis.

Expert groups disagree on the value of various preventive interventions, and thus are often at variance in the policies they endorse. The reasons for these variations are complex, and include different thresholds for statistical significance, the use of evidence based on study group efficacy as opposed to population effectiveness, and political pressures. Despite the lack of universally accepted approaches, there are numerous areas where at least some consensus exists, allowing for the formulation of a set of reasonable guidelines covering major interventions.

The attached guidelines represent an approach to preventive care synthesized from the available medical literature, reviewed by physicians practicing in Blue Cross Blue Shield of Oklahoma’s PPO managed care networks and BlueLincs HMO network, and adopted by the Quality Improvement Committee. They are organized into five age groups, and include those interventions that are recommended, those that are recommended against, and those for which no recommendation is stipulated. This latter category includes interventions for which supportive evidence is equivocal or not available, or highly dependent upon individual patient history, symptoms or risk. These interventions are left to individual physician discretion.

It is important to note that unless specified, the stated guidelines are meant to apply to average risk, asymptomatic and otherwise healthy individuals. Preventive care interventions appropriate for those at other levels of risk, increased or decreased, will vary by individual circumstance, and physicians are encouraged to tailor the approach to these patients as necessary.

Blue Cross Blue Shield of Oklahoma and BlueLincs HMO offer several distinct benefit plans, and Blue Cross Blue Shield of Oklahoma administers various self-funded plans and plans for Federal employees. Always refer to the member's official plan documents - including (but not limited to) summary plan descriptions, member contracts and benefit booklets - for specific questions regarding benefit coverage regarding any of the preventive health services discussed in the attached guidelines.
KEY TO MAJOR PROFESSIONAL ORGANIZATIONS
REFERENCE AS GUIDELINE AUTHORITY

AAP - American Academy of Pediatrics
ACIP - Advisory Committee on Immunization Practices
ACS - American Cancer Society
ACP - American College of Physicians
ACOG - American College of Obstetrics & Gynecology
AAFP - American Academy of Family Practice
AHA - American Heart Association
ADA - American Diabetes Association
BCBSA - Blue Cross Blue Shield Association
CDC - Centers for Disease Control & Prevention
CTF - Canadian Task Force
JNC - Joint National Commission On The Detection, Evaluation & Treatment of High Blood Pressure
NCEP - National Cholesterol Education Program
NCI - National Cancer Institute
NHLBI - National Heart Lung Blood Institute
OHCA - Oklahoma Health Care Authority
PDR - Physician’s Desk Reference
USPSTF - U.S. Preventive Services Task Force
Preventive Health Care Guidelines — Section I

PREVENTIVE HEALTHCARE SERVICES
PREGNATAL AND PERINATAL (TO AGE ONE MONTH) CARE

I. Recommended Interventions

A. Diabetes mellitus under control at time of conception; screen for Diabetes at 28 weeks gestation

Authority: ADA

B. ABO and D (formerly Rh) blood typing and antibody testing

1. For all pregnant women at first prenatal visit
2. Repeat antibody testing for all unsensitized D-negative women at 24-28 weeks, unless father is known to be D-negative.

Authority: ACOG, CTF, USPSTF

C. D immunoglobulin administration

1. At 24-28 weeks gestation if antibody negative on test unless father is known to be D-negative
2. Within 72 hours of delivery if infant is D-positive
3. After elective abortion or amniocentesis unless father is known to be D-negative
4. After abdominal trauma or maternal bleeding unless father is known to be D-negative

Authority: ACOG, CTF, USPSTF

D. Screening for asymptomatic bacteriuria with urine culture for all pregnant women by at 12 to 16 weeks of gestation.

Authority: CTF, USPSTF

E. Offer amniocentesis or chorionic villus sampling for chromosome studies for pregnant woman at high risk for Down syndrome (advance maternal age, previous affected pregnancy, known carriage of translocations)

Authority: ACOG, CTF, USPSTF

F. Screening/prevention of neural tube defects
Preventive Health Care Guidelines — Section I

1. Daily multivitamins with folic acid for all women planning or capable of pregnancy
2. Offering of screening for defects by maternal serum alpha-fetoprotein measurement at 15-20 weeks gestation, if accompanied by adequate counseling and follow-up.

Authority: AAP, ACOG, CTF, USPSTF

G. Screening for HIV

1. High-risk women (I.V. drug use, past or present; multiple sex partners; past or present sex partners HIV positive)
2. Offer to all pregnant women.

Authority: CDC, USPSTF

H. Screening for hemoglobinopathies

1. Pregnant women who are members of ethnic or racial groups with high incidence; carrier identified should be encouraged to have the father tested.

Authority: AAFP, ACOG, CTF, USPSTF

I. Screening for Hepatitis B, Rubella titers

1. If mother positive for Hepatitis B, newborn to be treated with immune globulin within 12 hours of birth; if negative, may be immunized routinely.
2. If Rubella titers are negative, mother should be immunized immediately after delivery with either Rubivax or MMR.

J. Screening for phenylketonuria

1. All newborns prior to discharge from nursery
2. Repeat test prior to 2 weeks of age if initial test before 24 hours of age

Authority: AAP, ACOG, CTF, USPSTF

K. Screening for congenital hypothyroidism

1. All newborns prior to discharge from nursery
2. Optimal: days 2-6

Authority: AAP, CTF, USPSTF
Preventive Health Care Guidelines — Section I

L. Offer screening for cystic fibrosis to those at higher risk of having children with cystic fibrosis (caucasians, including Ashkenazi Jews).

Authority: ACOG

M. Influenza immunization for women pregnant during the flu season.

Authority: ACIP, CDC, ACOG

II. Interventions Recommended Against

These include procedures or tests for which value in routine screening is not supported by current scientific literature, nor do endorsements exist by the consensus of major professional organizations.

A. Routine electronic fetal monitoring for low-risk woman in labor (when adequate clinical monitoring is available)
B. Home uterine activity monitoring

Authority: USPSTF

III. Interventions with No Specific Recommendations

These include interventions for which evidence of screening application is equivocal or not available or highly dependent on individual history of symptoms or risk. These interventions are left to individual physician’s discretion.

A. Intrapartum electronic fetal monitoring for high-risk pregnant women
B. Routine use of aspirin to prevent pre-eclampsia or intrauterine growth retardation

Authority: USPSTF
I. **Recommended Interventions**

The purposes of routine childhood healthcare are to foster normal development of children from infancy to early adulthood, and to help assure that each child achieves his or her full physical, intellectual and emotional adult potential.

A. **History and Physical Examination** (Authority: AAP for 1 - 5)

1. General physical exam
   - Extent determined by physician
   - Performed at:
     * Months:  1  2  4  6  9  12  15  18  24
2. Height and weight
   - Record at these points:
     * Months:  1  2  4  6  9  12  15  18  24
3. Head circumference
   - Record at these points:
     * Months:  2  4  6  9  12
4. Vision screen
   - Subjective at each exam
5. Hearing Screen
   - Subjective at each exam

B. **Immunizations**

   - Appendix A contains the recommended immunization schedules for the ages 0-6 years as published in the MMWR, ([www.cdc.gov](http://www.cdc.gov)).

   Authority: AAP, CDC, ACIP

C. **Lead Screening**

   - Risk assessment with questionnaire at 6 months
   - Blood lead screening at 12 and 24 months; beginning at 6 months for those at high risk, with periodicity as per EPSDT schedule

   Authority: CDC, OHCA
Preventive Health Care Guidelines — Section I

- Tuberculin skin testing
  - If increased risk of developing tuberculosis (HIV positive, close contact with known or suspected tuberculosis patient, immigrants from countries with high incidence, high risk groups)
  
  Authority: CDC

II. Interventions Recommended Against

- Screening for asymptomatic bacteriuria

  Authority: USPSTF
I. **Recommended Interventions**

The purposes of routine childhood healthcare are to foster normal development of children from infancy to early adulthood, and to help assure that each child achieves his or her full physical, intellectual and emotional adult potential.

A. **History and Physical Examination (Authority: AAP for 1 - 6)**

1. General physical exam  
   - Extent determined by physician  
   - Performed at:  
     Years: 2 3 4 5 6 10 12 14 16 18
2. Height and weight  
   - Record at these points:  
     Years: 2 3 4 5 6 10 12 14 16 18
3. Blood pressure  
   - Record at these points:  
     Years: 3 4 5 6 10 12 14 16 18
4. Vision screen  
   - Objective check at these points:  
     Years: 4 5 6 12 14 16 18
5. Hearing screen  
   - Objective check at these points:  
     Years: 4 5 12
6. Counseling (with parental consent)  
   - For sexual behavior: 10 12 14 16 18 years  
   - For substance abuse: 10 12 14 16 18 years
7. **Age Appropriate Health Counseling**  
   - Including discussion and assessment of tobacco use, sexual behavior, dental care, diet, nutrition, substance abuse, stress management, exercise, injury prevention  
   - May be accomplished by the distribution of appropriate literature

Authority: ACP, USPSTF, CTF

B. **Diagnostic Testing**

1. Fasting plasma glucose every 2 years beginning at age 10 for children who are overweight (BMI >85th percentile, weight for height >85th
Preventive Health Care Guidelines — Section I

percentile or weight >120% of ideal body weight) plus any two the following: History of type 2 diabetes or gestational diabetes, higher risk race/ethnicity, signs of insulin resistance, or maternal history of diabetes.

Authority: ADA

2. Syphilis serology, gonococcal culture, chlamydia screen - as necessary for those at risk for sexually transmitted diseases.

Authority: USPSTF

3. Pap Smear - Annually for females who are or have been sexually active

Authority: USPSTS, CTF

C. Immunizations (www.cdc.gov)

- Appendix A contains the recommended immunization schedules for the ages 0 – 6 years as published in the MMWR.
- Appendix B contains the recommended immunization schedules for the ages 7 – 18 years as published in the MMWR.

Authority: CDC, AAP, ACIP, AAFP

II. Interventions Recommended Against

Screening for asymptomatic bacteriuria

Authority: USPSTF

III. Interventions With No Specific Recommendations

Screening for hypercholesterolemia

Authority: USPSTF
Preventive Health Care Guidelines — Section I

PREVENTIVE HEALTHCARE SERVICES
ADULT
AGES 20-64

I. Recommended Interventions

A. History and Physical Examination
   1. Height and weight measurement
      • Record weight every two (2) years over age 18. Height once and as necessary
      • Annual height measurement in post-menopausal females
      Authority: AHA

   2. Blood pressure measurement
      • Every two (2) years over age 18
      • Note: For males age 18-39, guidelines for weight, blood pressure and health counseling may be met by an initial contact for evaluation and education, with subsequent periodic checks by allied health personnel, at the individual’s direction
      Authority: ACP, USPSTF, JNC

   3. Bimanual pelvic exam (female only)
      • Annually
      Authority: AAFP, AAP, ACOG, ACS, NCI

   4. Testicular exam (male only)
      • Self-exam taught by age 18, performed monthly
      • Clinical exam every two (2) years age 18-40
      Authority: ACS

   5. Digital rectal exam
      • Annually over age 50 at physician discretion
      Authority: ACS, USPSTF

   6. Clinical breast exam (female only)
      • Self-exam taught by age 40, performed monthly
      • Yearly over age 40
      Authority: ACP, USPSTF, CTF, ACS, BCBSA
Preventive Health Care Guidelines — Section I

7. Health Counseling
   • Including discussion and assessment of tobacco use, sexual behavior, dental care, diet, nutrition, substance abuse, stress management, exercise, injury prevention, hypertension screening, obesity
   • May be accomplished by the distribution of appropriate literature

Authority: ACP, USPSTF, CTF

B. Diagnostic Testing

1. Cholesterol
   • Fasting lipoprotein profile, every five (5) years over age 20
   • Complete lipoprotein profile recommended:
   • Total cholesterol, LDL, HDL, Triglyceride
     *Total cholesterol between 200-239 mg/dl and two or more CHD risk factors present (See Blue Cross and Blue Shield of Oklahoma and BlueLincs HMO Cholesterol Guidelines)

Authority: NHLBI

2. Fasting plasma glucose
   • Consider for age 45 and above every 3 years, particularly if BMI >25 g/m2
   • Consider before age 45 for BMI >25 and additional risk factors.

Authority: ADA

3. Screening mammography (female only)
   • Performed annually age 50 and over, every 1-2 years age 40-49 at physician discretion

Authority: ACP, USPSTF, CTF, ACS, BCBSA

4. Pap smear (female only)
   • Every 1 to 3 years based on risk factors; with or without HPV at physician discretion

Authority: ACS, ACOG, USPSTF

• Should maintain routine after hysterectomy, if any history of gynecologic malignancy or cervical dysplasia

Authority: USPSTF
5. Chlamydia screening
   • Sexually active, 25 years old and younger
   • Others of increased risk

   Authority: ACOG, USPSTF

6. Stool Occult Blood
   • Annually age 50 and over at physician discretion

   Authority: ACP, ACS, BCBSA

7. Endoscopy for colorectal cancer screening
   • Begin at age 50
   • Flexible sigmoidoscopy every 5 - 10 years
   • Colonoscopy every 10 years

   Authority: ACP, ACS, BCBSA

8. PSA - Prostate Specific Antigen (male only)
   • Begin at age 50
   • Offer annually age 40 and over for high risk patients
     (family history, African American)

   Authority: Oklahoma State Law, ACS

C. Immunizations
   • Appendix C contains the recommended immunization schedule for
     ages 19 – 64 years as published in the MMRR (www.cdc.gov).

   Authority: CDC, ACIP, AAFP

II. Interventions Recommended Against

These include procedures or tests for which value in routine screening is not supported by
current scientific literature, nor do endorsements exist by the consensus of major professional
organizations.

   Routine resting ECG
   Screening exercise/stress ECG
   Screening chest x-ray
   Ovarian cancer screening (CA-125, ultrasound)
   Routine biochemical profiles
Preventive Health Care Guidelines — Section I

Thyroid function
Urinalysis

Authority: ACP, CTF, USPSTF, BCBSA

III. Interventions With No Specific Recommendations

These include interventions for which evidence of screening application is equivocal or not available or highly dependent on individual history of symptoms or risk. These interventions are left to individual physician’s discretion.

- Vision screening
- Hearing screening
- Testing for cognitive impairment
- Assessment of depression, suicidal tendency
- Routine common blood tests: hemoglobin/hematocrit
- Flexible sigmoidoscopy
- Oral cavity exam to detect oral cancer
- Skin exam for cutaneous malignancy

Authority: USPSTF
Preventive Health Care Guidelines — Section I

PREVENTIVE HEALTHCARE SERVICES
ADULT
AGE 65 AND OVER

I. Recommended Interventions

A. History and Physical Examination

1. Height and weight measurement
   • Record weight every two (2) years. Height once and as necessary in males.
   • Annual height measurement in females

   Authority: AHA

2. Blood pressure measurement
   • Every year

   Authority: ACP, USPSTF, JNC

3. Digital rectal exam
   • Annually at physician discretion

   Authority: ACS, USPSTF

4. Clinical breast exam (female only)
   • Self-exam performed monthly through age 69
   • Yearly through age 69
   • Age 70 and over on an individual basis

   Authority: USPSTF

5. Health Counseling
   • Including discussion and assessment of tobacco use, sexual behavior, dental care, diet, nutrition, substance abuse, stress management, exercise and injury prevention
   • May be accomplished by the distribution of appropriate literature

   Authority: ACP, USPSTF, CTF

B. Diagnostic Testing

1. Cholesterol
   • Fasting lipoprotein profile, every five (5) years at discretion of physician
   • Complete lipoprotein profile recommended if:
Preventive Health Care Guidelines — Section I

* Total cholesterol over 240 mg/dl
* HDL less than 40 mg/dl
* total cholesterol between 200-239 mg/dl and two or more CHD risk factors present (See Blue Cross and Blue Shield of Oklahoma and BlueLincs HMO Cholesterol Guidelines)

Authority: NCEP

2. Fasting plasmaglucose - every 3 years, particularly if BMI >25 g/m2

Authority: ADA

3. Screening mammography (female only)
   • Performed annually through age 69
   • Age 70 and over on an individual basis

Authority: USPSTF

4. Stool Occult Blood
   • Annually, at physician discretion

Authority: ACP, ACS, BCBSA

5. Endoscopy for colorectal cancer screening
   • Flexible Sigmoidoscopy every 5 - 10 years
   • Colonoscopy every 10 years

Authority: ACP, ACS, BCBSA

6. PSA - Prostate Specific Antigen (male only)
   • Offered annually age 50 and over

Authority: Oklahoma State Law, ACS

C. Immunizations

• Appendix C contains the recommended immunization schedule for ages 65 and older (www.cdc.gov).

Authority: CDC, ACIP, AAFP
Preventive Health Care Guidelines — Section I

II. Interventions Recommended Against

These include procedures or tests for which value in routine screen is not supported by current scientific literature, nor do endorsements exist by the consensus of major professional organizations.

- Routine resting ECG
- Screening exercise/stress ECG
- Screening chest x-ray
- Ovarian cancer screening (CA-125, ultrasound)
- Routine biochemical profiles
- Thyroid function

Authority: ACP, CTF, USPSTF, BCBSA

III. Interventions With No Specific Recommendations

These include interventions for which evidence of screening application is equivocal or not available or highly dependent on individual history of symptoms or risk. These interventions are left to individual physician’s discretion.

- Vision screening
- Hearing screening
- Testing for cognitive impairment
- Assessment of depression, suicidal tendency
- Routine common blood tests: hemoglobin/hematocrit
- Urinalysis
- Bimanual pelvic exam (females)
- Pap smear in those females with prior normal regular exams
- Testicular exam (males)
- Oral cavity exam to detect oral cancer
- Skin exam for cutaneous malignancy

Authority: USPSTF
Interventions Recommended for Select Populations

1. HIV Serology
   - Annually (or periodically) for:
     - Male with same sex partner
     - IV drug use or history of same
     - Male or female prostitute or multiple sex partners
     - HIV positive partner

Authority: USPSTF, CDC

2. TB skin test (PPD)
   - Annually if:
     - TB case exposure in the home
     - Recent immigrant from high risk area
     - HIV positive or immunosuppressed condition
     - Chronic renal failure

Authority: USPSTF, CDC, CTF

3. Syphilis serology, gonococcal culture, chlamydia screen
   - As necessary for those at risk for sexually transmitted diseases

Authority: USPSTF

4. Immunizations - Appendix D contains the immunization schedule for medical and other conditions as published in the MMWR (www.cdc.gov)

5. Screening Endoscopy
   - High risk patients: familial polyposis, ulcerative colitis, adenomatous polyps, prior colon cancer, history of first degree relative with colon cancer
   - Referral to specialist is appropriate for these high-risk patients

Authority: USPSTF

6. Bone Density Screening
   - High risk women for osteoporosis
   - Women with an estrogen hormone deficiency; with vertebral abnormalities, primary hyperparathyroidism, or a history of fragility bone fractures; who is receiving long-term glucocorticoid who is being treated with Arimidex, or who is currently under treatment for osteoporosis.

Authority: Oklahoma State Law, PDR
Preventive Health Care Guidelines — Section I

APPENDIX A

Recommended Immunization Schedule for Persons Aged 0–6 Years—UNITED STATES • 2007

This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2007, for children aged 0–6 years. Additional information is available at: www.cdc.gov/vaccines. Providers must administer the recommended vaccines at any subsequent visit, unless indicated otherwise. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any component of the combination is indicated and other components of the vaccine are not contraindicated and approved by the Food and Drug Administration for that dose of the vaccine. Providers should consult the respective Advisory Committee on Immunization Practices statement for detailed recommendations. Closely follow immunization schedule but follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about when to admin and complete a VRIS form is available at: http://www.vaers.hhs.gov or by telephone: 1-800-822-7967.

1. Hepatitis B vaccine (HepB). (Minimum age: birth)
   - At birth: Administer monovalent HepB to all newborns before hospital discharge.
   - If母亲 has positive surface antigen (HBsAg-positive, administer HepB and 0.5 mL of hepatitis B immune globulin (HIBiG) within 12 hours of birth.
   - If mother’s HBsAg status is unknown, administer HepB within 12 hours of birth. Determine the HBsAg status as soon as possible and if HBsAg-positive, the birth dose can only be delayed with physician’s order and mother’s negative HBsAg laboratory report documented in the infant’s medical record.
   - After the birth dose:
     - The HepB series should be completed with either monovalent HepB or a combination vaccine containing HepB. The second dose should be administered at 1–2 months. The final dose should be administered at age 4–6 months, infants born to HBsAg-positive mothers should be tested for HBsAg and antibody to HBsAg after completion of 2 doses of a licensed HepB series by age 18–24 months (generally at the well-child visit).
     - 4-month doses:
       - It is permissible to administer 4 doses of HepB when combination vaccine are administered after birth dose. If monovalent HepB is used for doses after the birth dose, a dose at age 4 months is not needed.
   - 2. Rotavirus vaccine (Rotavirus). (Minimum age: 6 weeks)
     - Administer the first dose at age 6–12 weeks. Do not start the series later than age 12 weeks.
     - Administer the first dose in the series by age 22 weeks. Do not administer a dose later than age 22 weeks.
     - Data on safety and efficacy outside of these age ranges are insufficient.
   - 3. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP). (Minimum age: 2 months)
     - The fourth dose of DTaP may be administered as early as age 6 months, provided 6 months have elapsed since the third dose.
     - The first dose of the series at age 6–18 months.
   - 4. Haemophilus influenzae type b conjugate vaccine (Hib). (Minimum age: 6 weeks)
     - If PRP-OMP (PedvaxHib® or Comvax® [Merck]) is administered at ages 2 and 4 months, a dose at age 6 months is not required.
     - If HibTITER® (DTaP-Hib) combination products should not be used for primary immunization but can be used as boosters following any Hib vaccine in children aged 6–12 months.
   - 5. Pneumococcal vaccine. (Minimum age: 6 weeks for pneumococcal conjugate vaccine [PCV]; 2 years for pneumococcal polysaccharide vaccine [PPV])
     - Administer PCV at ages 2–6 months in certain high-risk groups.
   - 6. Influenza vaccine. (Minimum age: 6 months for inactivated influenza vaccine [IIV]; 9 months for the attenuated influenza vaccine [LAIV])
     - All children aged 6–59 months and close contacts of all children aged 6–59 months are recommended to receive influenza vaccine.
     - Influenza vaccine is recommended annually for children aged 6–59 months with certain risk factors, healthcare workers, and other cases (including household members in close contact with persons in groups at high risk. See MMWR 2006;55(RR):10–11.)
     - For healthy persons aged 50–69 years, LAIV may be used as an alternative to IIV.
     - Children receiving IIV should receive 0.25 mL at age 6–24 months or 0.5 mL if aged 2–3 years.
     - Children aged >9 years who are receiving influenza vaccine for the first time should receive 2 doses (separated by ≥4 weeks for IIV and ≥6 weeks for LAIV).
   - 7. Measles, mumps, and rubella vaccine (MMR). (Minimum age: 12 months)
     - Administer the second dose of MMR at age 4–6 years. MMR may be administered before age 4–6 years, provided ≥4 weeks have elapsed since the first dose and both doses are administered at age ≥12 months.
   - 8. Varicella vaccine. (Minimum age: 12 months)
     - Administer the second dose of varicella vaccine at age 4–6 years. Varicella vaccine may be administered before age 4–6 years, provided ≥4 weeks have elapsed since the first dose and both doses are administered at age ≥12 months. If second dose was administered ≥28 days following the first dose, the second dose does not need to be repeated.
   - 9. Hepatitis A vaccine (HepA). (Minimum age: 12 months)
     - HepA is recommended for all children aged 1 year (i.e., aged 12–23 months). The 2 doses in the series should be administered at least 6 months apart.
     - Children not fully vaccinated by age 2 years can be vaccinated at subsequent visits.
     - HepA is recommended for certain other groups of children, including in areas where vaccination programs target older children. See MMWR 2002;51(RR):1–22.
   - 10. Meningooccal polysaccharide vaccine (MPSV4). (Minimum age: 2 years)
     - Administer MPSV4 to children aged 2–10 years with terminal complement deficiencies of any cause or functional asplenia and certain other high-risk groups. See MMWR 2002;51(RR):1–22.

The Recommended Immunization Schedule for Persons Aged 0–18 Years are approved by the Advisory Committee on Immunization Practices (http://www.cdc.gov/vaccines).
### Preventive Health Care Guidelines — Section I

#### APPENDIX B

**Recommended Immunization Schedule for Persons Aged 7–18 Years — UNITED STATES • 2007**

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Age Group</th>
<th>7–10 years</th>
<th>11–12 years</th>
<th>13–14 years</th>
<th>15 years</th>
<th>16–18 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus, Diphtheria, Pertussis</td>
<td>6 doses</td>
<td>TDap</td>
<td>TDap</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human Papillomavirus</td>
<td>2 doses</td>
<td>HPV (3 doses)</td>
<td>HPV Series</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meningococcal</td>
<td>1 dose</td>
<td>MCV4</td>
<td>MCV4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal</td>
<td>1 dose</td>
<td>PPV</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influenza</td>
<td></td>
<td>Influenza (Yearly)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis A</td>
<td></td>
<td>HepA Series</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td></td>
<td>HepB Series</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inactivated Poliovirus</td>
<td></td>
<td>IPV Series</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles, Mumps, Rubella</td>
<td></td>
<td>MMR Series</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella</td>
<td></td>
<td>Varicella Series</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2006, for children aged 7–18 years. Additional information is available at http://www.cdc.gov/vaccines/schedules/hcp/cvact-sched.pdf. Any dose not administered at the recommended age should be administered at any subsequent visit, when indicated and feasible. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and other components of the vaccine are not contraindicated and if approved by the Food and Drug Administration for that dose of the series. Providers should consult the Advisory Committee on Immunization Practices statement for detailed recommendations. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS), Guidance about how to obtain and complete a VAERS form is available at http://www.vaers.hhs.gov or by telephone: 800-822-7967.

1. Tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap). (Minimum age: 10 years for BOOSTRIX® and 11 years for ADACEL®)
   - Administer at age 11–12 years for those who have completed the recommended childhood DTP/DTaP® vaccination series and have not received a tetanus and diphtheria toxoids vaccine (Td) booster dose.
   - Adolescents aged 13–18 years who missed the 11–12 year Td booster dose should receive a single dose of Tdap if they have completed the recommended childhood DTP/DTaP® vaccination series.

2. Human papillomavirus vaccine (HPV). (Minimum age: 9 years)
   - Administer the first dose of the HPV vaccine series to females at age 11–12 years.
   - Administer the second dose 2 months after the first dose and the third dose 6 months after the first dose.
   - Administer the HPV vaccine series to females at age 13–18 years if not previously vaccinated.

3. Meningococcal vaccine. (Minimum age: 11 years for meningococcal conjugate vaccine [MCV4]; 2 years for meningococcal polysaccharide vaccine [MPSV4])
   - Administer MCV4 at age 11–12 years and a previously unvaccinated adolescent at high school entry (at approximately age 16 years).
   - Administer MCV4 to previously unvaccinated college freshmen living in dormitories; MPSV4 is an acceptable alternative.
   - Vaccination against invasive meningococcal disease is recommended for children and adolescents aged >2 years with bacteraemia and certain other high-risk groups. See MMWR 2005;54(RR-7):1–21. Use MCV4 for children aged 2–10 years and MPSV4 or MCV4 for older children.

4. Pneumococcal polysaccharide vaccine (PPV). (Minimum age: 2 years)

5. Influenza vaccine. (Minimum age: 6 months for inactivated influenza vaccine [IIV]; 5 years for live, attenuated influenza vaccine [LAIV])
   - Influenza vaccine is recommended annually for persons with certain risk factors, health-care workers, and other persons (including household members) in close contact with persons in high-risk settings. See MMWR 2006;55(RR-10):1–41.
   - For persons aged 5–40 years, LAIV may be used as an alternative to IIV.
   - Children aged <5 years who are receiving influenza vaccine for the first time should receive 2 doses (separated by ≥2 weeks for IIV and ≥4 weeks for LAIV).

6. Hepatitis A vaccine (HepA). (Minimum age: 12 months)
   - The 2 doses in the series should be administered at least 6 months apart.
   - HepA is recommended for certain other groups of children, including those in areas where vaccination programs target older children. See MMWR 2006;55(RR-10):1–23.

7. Hepatitis B vaccine (HepB). (Minimum age: birth)
   - Administer the 3 doses series to those who were not previously vaccinated.
   - A 2-dose series of Recombivax HB® is licensed for children aged 11–15 years.

8. Inactivated poliovirus vaccine (IPV). (Minimum age: 6 weeks)
   - For children who received an IPV or all-polio vaccine (OPV) series, a fourth dose is not necessary if the third dose was administered at age ≥4 years.
   - If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age.

9. Measles, mumps, and rubella vaccine (MMR). (Minimum age: 2 months)
   - If not previously vaccinated, administer 2 doses of MMR during any visit, with ≥2 weeks between the doses.

10. Varicella vaccine. (Minimum age: 12 months)
    - Administer 2 doses of varicella vaccine to persons without evidence of immunity.
    - Administer 2 doses of varicella vaccine to persons aged >12 years at least 3 months apart. Do not repeat the second dose, if administered ≥28 days after the first dose.
    - Administer 2 doses of varicella vaccine to persons aged ≥12 years at least 4 weeks apart.

The Recommended Immunization Schedule for Persons Aged 6–18 Years are approved by the Advisory Committee on Immunization Practices (http://www.cdc.gov/mmwr/), the American Academy of Pediatrics (http://www.aap.org), and the American Academy of Family Physicians (http://www.aafp.org).

SAFER • HEALTHIER • PEOPLE
## Preventive Health Care Guidelines — Section I

### APPENDIX C

**Recommended Adult Immunization Schedule**
United States, October 2006–September 2007

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>19–49 years</th>
<th>50–64 years</th>
<th>≥65 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus, diphtheria, pertussis (Td/Tdap)**</td>
<td>1 dose Td booster every 10 yrs</td>
<td>Substitute 1 dose of Tdap for Td</td>
<td></td>
</tr>
<tr>
<td>Human papillomavirus (HPV)**</td>
<td>2 doses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles, mumps, rubella (MMR)**</td>
<td>1 or 2 doses</td>
<td>1 dose</td>
<td></td>
</tr>
<tr>
<td>Varicella*</td>
<td>2 doses</td>
<td>2 doses</td>
<td></td>
</tr>
<tr>
<td>Influenza*</td>
<td></td>
<td>1 dose annually</td>
<td>1 dose annually</td>
</tr>
<tr>
<td>Pneumococcal (polysaccharide)*</td>
<td>1–2 doses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis A*</td>
<td>2 doses</td>
<td>2 doses</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B*</td>
<td>3 doses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meningococcal†</td>
<td>1 or more doses</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### APPENDIX D

**Recommended Adult Immunization Schedule**, by vaccine and medical and other indications

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Requirement: Pregnant or immunocompromised</th>
<th>Requirement: Chronic or Acute Condition</th>
<th>Requirement: Chronic or Acute Condition</th>
<th>Requirement: Chronic or Acute Condition</th>
<th>Requirement: Chronic or Acute Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus, diphtheria, pertussis (Td/Tdap)**</td>
<td>1 dose Td booster every 10 yrs</td>
<td>Substitute 1 dose of Tdap for Td</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human papillomavirus (HPV)**</td>
<td>2 doses</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles, mumps, rubella (MMR)**</td>
<td>1 or 2 doses</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella*</td>
<td>2 doses</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influenza*</td>
<td>1 dose annually</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal (polysaccharide)*</td>
<td>1–2 doses</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis A*</td>
<td>2 doses</td>
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<td></td>
</tr>
<tr>
<td>Hepatitis B*</td>
<td>3 doses</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meningococcal†</td>
<td>1 or more doses</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Covered by the Vaccine Injury Compensation Program

These recommendations must be read along with the footnotes, which can be found on the next 2 pages of this schedule.

For all persons in this category who meet the age requirements and who lack evidence of immunity (e.g., lack documentation of vaccination or have no evidence of prior infection):

Recommended if another risk factor is present (e.g., on the basis of medical, occupational, lifestyle, or other indications)

Contraindicated
SAMPLE FORMS — Section I

BlueCross BlueShield of Oklahoma
REQUEST FOR PROFESSIONAL BILLING NUMBER

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
</tr>
</thead>
</table>

Group Affiliation: __________________________________________

Office (Physical) Address: ________________________________

_________________________  ___________________________  __________
City          State       Zip Code

Payment Address: ________________________________

_________________________  ___________________________  __________
City          State       Zip Code

Telephone Number: ___________  Fax Number: ___________

State License Number: __________________________

*** Copy of State License is Required***

Social Security Number: ___________  Date of Employment: ___________

Tax Identification Number: ___________  Primary Specialty: ___________

Medicare UPIN #: ___________  Medicare Number: ___________

NPI (National Provider Identifier) Number: ___________

Contact person in Office: __________________________

Comments: __________________________

COMPLETION OF THIS FORM DOES NOT MEAN THAT YOU ARE A CONTRACTED PROVIDER

Authorized Signature: __________________________  Date: ___________

***Please attach a completed & signed W-9 Form****

Office hours: __________________________

Return to:  BlueCross BlueShield of Oklahoma Health Industry Relations

PO Box 3283 or PO Box 60545
Tulsa, OK 74102-3283 or Oklahoma City, OK 73146-0545
Fax: (918)551-3413 or Fax: (405)316-7134

Attention: __________________________
BLUECROSS BLUESHIELD OF OKLAHOMA
REQUEST FOR FACILITY PROVIDER NUMBER

Facility DBA NAME: ________________________________________________________________

Physical Address: ________________________________________________________________

_________________________________________________________________________________

City                                           State                                           Zip Code

Payment Address: ________________________________________________________________

_________________________________________________________________________________

City                                           State                                           Zip Code

Physical Location Phone Number_______________Emergency Phone number ______________Fax number_____________

Required documents State License, Medicare Certification Letter, W-9 Please attach the necessary forms

State License Number: ______________  Medicare Number: _____________ Tax Identification Number:_______________

(If applicable)

NPI (National Provider Identifier) Number: _____________________________________________

*** Copy of Enumerator Document must be supplied ***

Primary Specialty: ____________________________________________________________________________________

Date the Facility opened its doors for business:

______________________________________________________________________________________________

Contact person in Office: ____________________________________________________________ Phone Number:__________________

Comments:

______________________________________________________________________________________________

______________________________________________________________________________________________

______________________________________________________________________________________________

COMPLETION OF THIS FORM DOES NOT MEAN THAT YOU ARE A CONTRACTED PROVIDER. If
information is not received within 5 business days any pending claims will be returned.

Authorized Signature Required: ___________________________________Date_________________________

Return To: BlueCross BlueShield of Oklahoma Health Industry Relations

P O Box 3283 or PO Box 60545
Tulsa OK  74102-3283 Oklahoma City Ok  73146-0545
Fax Number: 918-551-3413 Fax number: 405-316-7134

Attention: ________________________________________________________________
PRACTICE CHANGE INFORMATION FORM

Blue Cross Blue Cross Blue Shield of Oklahoma needs up-to-date provider practice information. Changes in your practice can affect your directory listing(s) and the process of your claims. If any of the following items listed in this form have changed recently, please complete this form. You may copy this form for future use. Mail the forms to the following address:

Blue Cross Blue Shield of Oklahoma
Health Industry Relations
P. O. Box 3283
Tulsa, OK  74102-3283

**********COPY OF STATE LICENSE IS REQUIRED**********

Provider Name    Provider 12-Digit Billing Number               National Provider Identifier

FROM:      TO:      Effective Date:

Name

Physical Address

City, State, Zip (plus 4)

Mailing Address (for payments)

City, State, Zip (plus 4)

( ) Office Phone #

( ) After Hours Phone #

Group/Clinic Affiliation

Tax ID Number*

PCP Call Coverage- Former Names:    PCP Call Coverage- Current Names:

* For any Tax ID change, please complete and attach a W-9 Form. The IRS requires us to keep a W-9 on file.
** Also, please complete and attach an Office Hours Form.

Attention PCP’s: Please note the request for your updated call coverage plan. Your patients may needlessly be penalized if we are unaware of recent changes.

Provider Rep: Office Contact Person:

Blue Cross and Blue Shield of Oklahoma Provider BluePrint Manual (05/08) 94
ADDITIONAL LOCATION

Blue Cross Blue Shield of Oklahoma
REQUEST FOR PROFESSIONAL BILLING NUMBER

Name
Title

Group Affiliation:________________________________________________________

Office (Physical) Address:_________________________________________________

__________________________________________  State  Zip Code
    City                 State     Zip Code
Payment Address:_________________________________________________________

__________________________________________  State  Zip Code
    City                 State     Zip Code

Telephone Number:_______________  Fax Number:___________________________

State License Number:___________________________________________________
*** Copy of State License is Required***

Social Security Number:__________  Date of Employment:____________________

Tax Identification Number:_______________________________________________

Primary Specialty:_______________________________________________________

Medicare UPIN #:_______________  Medicare Number:_______________________

NPI (National Provider Identifier) Number:_______________________________

Contact person in Office:________________________________________________

Comments:___________________________________________________________________

COMPLETION OF THIS FORM DOES NOT MEAN THAT YOU ARE A CONTRACTED PROVIDER

Authorized Signature:____________________________________  Date:__________

Office hours:___________________________________________________________

***Please attach a completed & signed W-9 Form***

Return to:  Blue Cross Blue Shield of Oklahoma Health Industry Relations
PO Box 3283  or  PO Box 60545
Tulsa, OK 74102-3283  Oklahoma City, OK 73146-0545
Fax: (918)551-3413  Fax: (405)316-7134

Attention:________________________________________________________________

Blue Cross and Blue Shield of Oklahoma Provider Blueprint Manual (05/08)  95
Blue Cross Blue Shield of Oklahoma
Request for Pharmacy Billing Number
(We will assign a # when the information is received)

Pharmacy DBA Name
Physical Address: ____________________________________________
City, State, Zip

Billing (Mailing)
Address: ____________________________________________________
City, State, Zip

Telephone Number:__(_____)_____________________________________
Fax Number:__ (____) __________________________________________

NPI (National Provider Identifier) Number: _________________________________
*** Copy of Enumerator Document must be supplied ***

Tax Identification Number:___________________________________________
(Please Attach W-9)
Pharmacy License Number: ___________________________________________

Do you handle DME supplies: YES NO

NABP Number: ____________________________________________________

Pharmacist’s Name: _______________________________________________

Contact Person: __________________________________________________

Date of store opening: ____________________________________________

Comments: _______________________________________________________

Authorized Signature:_____________________________________________ Date:____________________

Return To: Blue Cross Blue Shield of Oklahoma or Fax To: (918)551-3413
Health Industry Relations
PO Box 3283
Tulsa, OK  74102-3283

Authorized Signature:_____________________________________________ Date:____________________
**BLUELINCS HMO REFERRAL/AUTHORIZATION REQUEST**

Precertification Phone Number: 1.800.580.4454  
Precertification Fax Number: 1.918.551.3558

*Please call the Precertification Department for any MRI, Outpatient Surgery, Inpatient Admission or Out-of-Network Referral*

**DO NOT SEND ANY MEDICAL RECORDS WITH THIS REQUEST**

<table>
<thead>
<tr>
<th>Patients Name</th>
<th>BlueLincs ID#</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Request</td>
<td>Date of Birth</td>
</tr>
<tr>
<td>Initial Request</td>
<td>OR</td>
</tr>
<tr>
<td>Date of Service (if known)</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>PCP Name</th>
<th>Specialist</th>
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</thead>
<tbody>
<tr>
<td>Phone</td>
<td>Phone (___)</td>
</tr>
<tr>
<td>Fax</td>
<td>Fax (___)</td>
</tr>
<tr>
<td>Contact Person</td>
<td>Contact Person</td>
</tr>
</tbody>
</table>

| Request from PCP | OR | Specialist |
|------------------|----------|

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>CPT Codes</th>
<th>ICD 9</th>
</tr>
</thead>
</table>

List Facility, if applicable

Please circle your selection below. *If your selection is for a procedure, you must fill in the CPT code.*

1. Consultation and up to two follow-up visits. Date Range of Service: ____________
2. Consultation Only. Date of Service: ____________  
   a. _____ (If checked) No follow up allowed without additional PCP Referral
3. Emergency Room Visit: Date ____________ Did PCP send? _____ Yes _____ No
4. Obstetrical Care: (due date)
5. Durable Medical Equipment: (include HCPCS Code/s) ____________
6. Allergy Treatment-testing or serum: **YOU MUST COMPLETE ALLERGY AUTHORIZATION FORM**
7. Diagnostic Procedure: ____________

**ANY SERVICES NOT LISTED ABOVE, MUST BE PREAUTHORIZED BY BLUE LINC HMO**

<table>
<thead>
<tr>
<th>FOR BLUELINCSTAFF ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral number given by BlueLincs HMO</td>
</tr>
<tr>
<td>Authorization expires on</td>
</tr>
<tr>
<td>Comment:</td>
</tr>
</tbody>
</table>

*This referral does not guarantee payment for services provided. Payment depends upon member eligibility, benefits and participation in the BlueLincs Program. This form WILL NOT be processed unless all necessary information is completed.*

Blue Cross and Blue Shield of Oklahoma is a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association 10.560 (06/06)