Section 5: Blue Shield Benefit Plans and Programs
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Blue Shield Benefit Plans

Blue Shield offers a variety of benefit plans representing a cross section of financing and delivery systems to meet the various health care needs and budgets for subscribers of both group plans and individual plans.

This section gives a brief description of the following Blue Shield plans. More detailed plan information, including plan networks, can be found on blueshieldca.com/provider.

- HMO Plans
- PPO Plans
- Point of Service (POS) Plans
- Federal Employee Program (FEP)
- Medicare Supplement Plans
- The BlueCard® Program
- Other Payors

Blue Shield HMO Plans

Blue Shield offers the Access+ HMO® Plan and Local Access+ HMO Plan to Small Business and Core Account groups. Point-of-service (POS) and SaveNet HMO plans are included in the Core HMO family of products. Blue Shield offers Trio HMO plans to Small Business, Core, and individual and family plans (IFP) (on-exchange and mirrored only).

Blue Shield Access+ HMO is Blue Shield’s commercial HMO plan, which includes a unique direct access feature called Access+ Specialist™, which allows a member to access a specialist within his or her assigned medical group or IPA.

Custom employer groups may choose not to offer this direct access feature. The member’s identification card will designate if the member has the Access+ direct access feature. An "A+" appearing next to the network name on the card indicates that the subscriber has the Access+ Specialist feature.
Blue Shield HMO Plans (cont’d.)

Access+ SpecialistSM Feature

Access+ HMO members with the Access+ Specialist feature can self-refer directly to any primary care physician (PCP) or specialist (M.D. or D.O.) for a consultation, as long as that physician is in the same IPA/medical group as the member’s PCP.

The members simply present their ID card at the specialist’s office and pay their Access+ office visit copayment, which is generally higher than the standard office visit copayment.

After the consultation, if additional services or procedures are recommended, the specialist coordinates care with the member’s PCP and follows Blue Shield’s authorization process. If Blue Shield authorizes additional services/procedures, the HMO member may go back to the specialist for the authorized services and pay the usual office visit copayment.

An Access+ Specialist visit does not include:

- Any services which are not covered, or which are not medically necessary
- Services provided by a non-Access+ provider (such as podiatry and physical therapy), except for the X-ray and laboratory services described above
- Allergy testing
- Endoscopic procedures
- Any diagnostic imaging, including CT, MRI or bone density measurements
- Injectables, chemotherapy or other infusion drugs, other than vaccines and antibiotics
- Infertility services
- Emergency services
- Urgent services
- Inpatient services, or any services which result in a facility charge, except for routine X-ray and laboratory services
- Services for which the IPA/medical group routinely allows the member to self-refer without authorization from the primary care physician
- OB/GYN services by an obstetrician/gynecologist or family practice physician within the same IPA/medical group as the member's PCP
Blue Shield 65 Plus℠ (HMO) (Medicare Advantage)

Blue Shield 65 Plus℠ (HMO)¹ is Blue Shield’s Medicare Advantage-Prescription Drug (MA-PD) plans. These plans are open to all Medicare beneficiaries, including those under age 65 who are entitled to Medicare on the basis of Social Security disability benefits, who meet all of the applicable eligibility requirements for membership, have voluntarily elected to enroll in Blue Shield 65 Plus, have paid any premiums required for initial enrollment to be valid, and whose enrollment in Blue Shield 65 Plus, has been confirmed by the Centers for Medicare & Medicaid Services (CMS). Blue Shield 65 Plus is offered to individual Medicare beneficiaries and to group Medicare beneficiaries retired from employer groups/ unions who have selected the product as an option.

To be eligible for enrollment in the Blue Shield 65 Plus program, the member must have both Medicare Part A and Medicare Part B and live within the CMS-approved Blue Shield 65 Plus service area. Patients diagnosed with End Stage Renal Disease (ESRD) prior to signing an enrollment application, who have ongoing dialysis, are not eligible to join Blue Shield 65 Plus, unless they are already a Blue Shield commercial plan member and within their 30-month coordination period or were previously enrolled with another Medicare Advantage HMO that has subsequently withdrawn from their county. Once a kidney transplant has occurred and the individual no longer needs dialysis, he or she is eligible to enroll in Blue Shield 65 Plus. All other pre-existing conditions are covered without a waiting period.

The Blue Shield 65 Plus plan provides comprehensive coordinated medical services to members on a prepaid basis through an established provider network. Members must choose a primary care physician (PCP) and have all care coordinated through this physician. The Blue Shield 65 Plus (HMO) plan is regulated by the Centers for Medicare & Medicaid Services (CMS), the same federal agency that administers Medicare. Please contact Blue Shield 65 Plus Medicare Member Services (877) 654-6500 (for Providers), (800) 776-4466 (for Members), if you have questions about benefit information, eligibility, claims, and/or billing.

¹ When the manual references Blue Shield 65 Plus, it refers to Blue Shield’s Medicare Advantage-Prescription Drug plans: Blue Shield 65 Plus (HMO), Blue Shield 65 Plus Choice Plan (HMO), and Blue Shield Trio Medicare (HMO).
Medicare Part D

The Medicare Prescription Drug Improvement and Modernization Act (MMA) introduced the Medicare Advantage Program and the Prescription Drug Benefit. The prescription drug benefit, as well as an employer subsidy for qualified retiree health plans, is referred to as Medicare Part D. Coverage for the drug benefit is being provided by private prescription drug plans (PDPs) that offer drug-only coverage, or through Medicare Advantage plans that offer both prescription drug and health care coverage (known as Medicare Advantage – Prescriptions Drug Plans (MA-PD)).

Part D Eligibility

In general, an individual is eligible to enroll in a Medicare prescription drug plan (PDP) if:

1. The individual is entitled to Medicare Part A and/or enrolled in Part B, provided that he/she will be entitled to receive services under Medicare Part A and/or Part B as of the effective date of coverage under the plan; and
2. The individual permanently resides in the service area of a PDP.

Other eligibility requirements and exclusions include:

- An individual who is living abroad or is incarcerated is not eligible for Part D.
- For individuals whose Medicare entitlement determination is made retroactively, Part D eligibility begins with the month the individual receives the notice of the Medicare entitlement determination.
- A PDP sponsor may not deny enrollment to otherwise eligible individuals covered under an employee benefit plan. If the individual enrolls in a PDP and continues to be enrolled in his/her employers or spouse’s health benefits plan, then coordination of benefits (COB) rules will apply.
- A Part D eligible individual may not be enrolled in more than one Part D plan at the same time.

Fraud, Waste, and Abuse Requirements and Training

Blue Shield has a comprehensive program in place to detect, prevent and control Part D Fraud, Waste, and Abuse (FWA) as part of the General Compliance Plan Requirements (42 C.F.R. § 423.504(b)(4)(vi)(H)).

The Medicare Part D FWA training is a requirement under CMS for anyone who works with Medicare Part D. Blue Shield's Medicare Part D Compliance training is for contracted pharmacies to ensure these providers have a thorough understanding of federal and state regulations around Medicare Part D. Successful completion is required of anyone involved with the administration or delivery of the Part D benefit. The training focuses on how to detect, correct, and prevent fraud, waste, and abuse surrounding Medicare Part D. To access the online training, please go to https://www.blueshieldca.com/provider/about-this-site/announcements/medicare-compliance-training.sp.

A statement of attestation is required annually by all network pharmacies contracted with Blue Shield for the Medicare Prescription Drug Plans. The compliance statement of attestation indicates that the pharmacy staff completed the Medicare Part D Fraud, Waste, and Abuse Compliance training.
Medicare Part D (cont’d.)

Exclusion Lists

The Office of the Inspector General (OIG) excludes individuals and entities from participation in Medicare, Medicaid, the State Children’s Health Insurance Program (SCHIP), and all Federal health care programs (as defined in section 1128B(f) of the Social Security Act (the Act)) based on the authority contained in various sections of the Act, including sections 1128, 1128A, 1156, and 1892. The OIG and the General Services Administration (GSA) maintain a sanction lists that identifies those individuals and entities found guilty of fraudulent billing, misrepresentation of credentials, etc.

Therefore, CMS prohibits any employee, provider, contractor, or subcontractor from performing any activity related to Medicare Part D or other federal programs if they are listed in the General Services Administration (GSA) database of excluded individuals/entities or the Office of Inspector General’s (OIG) database of excluded individuals or entities. Below are links to these databases:

- [https://oig.hhs.gov/exclusions/index.asp](https://oig.hhs.gov/exclusions/index.asp)
- [https://www.sam.gov/portal/SAM](https://www.sam.gov/portal/SAM)

CMS requires that all entities review the lists prior to hiring or contracting of anyone and monthly thereafter to ensure that its employees, consultants, volunteers, board members, officers, first tier entities, downstream entities, or related entities that assist in the administration or delivery of Part D benefits are not included on such lists. If the first-tier entities, downstream entities, or related entities are on such lists, the entity’s policies shall require the immediate removal of such employees, board members, first tier entities, downstream entities, or related entities from any work related directly or indirectly on all Federal health care programs and take appropriate corrective actions. Upon audit, entities and providers must provide evidence that these monthly validation checks have been conducted.

Medicare Part D Prescriber Preclusion List

The Centers for Medicare & Medicaid Services (CMS) is eliminating the prescriber and provider enrollment requirement for Part C and Part D and instead is compiling a “Preclusion List” of prescribers, individuals, and entities that fall within either of the following categories: (a) are currently revoked from Medicare, are under an active reenrollment bar, and CMS determines that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program; or (b) have engaged in behavior for which CMS could have revoked the prescriber, individual, or entity to the extent applicable if they had been enrolled in Medicare, and CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program. CMS will make the Preclusion List available to Part D prescription drug plans and Medicare Advantage plans. Plans are required to deny payment for claims submitted by, or associated with, prescriptions written by prescribers and providers on the list. Full enforcement of the Part C and D prescriber exclusion list requirement will begin on January 1, 2019.

Additionally, the added provisions require organizations offering Part D to cover a three-month provisional supply of the drug and provide beneficiaries with individualized written notice before denying a Part D claim or beneficiary request for reimbursement on the basis of a prescriber’s being neither enrolled in an approved status nor validly opted out. The three-month provisional supply is intended to give the prescriber time to enroll in Medicare or opt-out and ensure beneficiary access to prescribed medication.
Medicare Part D (cont’d.)

Medication Therapy Management Program (MTMP)

Blue Shield provides a Medication Therapy Management Program (MTMP) for its Medicare Part D members to assist them in managing their chronic conditions. The Blue Shield MTMP is for members meeting all of the following criteria:

- Have two of the following conditions:
  - Respiratory Disease-Chronic Lung Disorders
  - Chronic Heart Failure (CHF)
  - Diabetes
  - Hypertension
  - Osteoporosis
- Receive seven or more different covered Part D prescriptions monthly
- Likely to incur an annual cost threshold established by CMS each calendar year for Medicare covered prescriptions

Members meeting these criteria will be automatically enrolled in the MTMP at no additional cost relating to the program and they may opt-out if they desire.

Members have the option to speak with a designated pharmacist to discuss their medication therapy issues. The pharmacist consultations are designed to improve member health while controlling out-of-pocket costs and may include topics such as:

- Drug adverse reactions
- Drug side-effects
- Drug-drug interactions
- Drug-disease interactions
- Medication non-compliance and non-adherence
- Duplicate therapy
- Dosing that can be consolidated
- Non-prescription drug use

A written summary of the consultation with relevant assessments and recommendations will be provided to the member. The member’s prescribing physician or primary care physician may be contacted by the pharmacist to coordinate care or recommend therapy changes when necessary.
Blue Shield PPO Plans

Under a Blue Shield PPO plan, members may self-refer to any provider. The highest benefits level (i.e., lowest out-of-pocket costs) will be paid when a Blue Shield Preferred Provider is used.

A member’s copayments and deductible amounts for covered services will vary depending on whether he or she selects a preferred hospital provider or a non-network hospital provider. Therefore, there is a financial incentive for members to use Blue Shield preferred hospital providers.

If a member chooses to go to a non-network hospital provider, Blue Shield’s payment for a service by that non-network hospital provider may be substantially less than the amount billed. The member is responsible for the difference between the amount Blue Shield pays and the amount billed by non-network hospital provider. It is therefore to the member’s advantage to obtain medical and hospital services from preferred hospital providers.

Our PPO Savings Plans (PSP) are PPO plans with a choice of deductibles, designed to allow qualified individuals to establish a tax advantaged account under federal guidelines. Most services provided by a preferred hospital provider require a percentage copayment.

All PSP plans function very differently than regular PPO plans. All benefits (including pharmacy) must accrue to the deductible. The only benefits that can be paid by Blue Shield prior to the deductible being met is preventive care. If a member chooses to go to a non-network hospital provider, Blue Shield’s payment for a service by that non-network hospital provider may be substantially less than the amount billed. The member is responsible for the difference between the amount Blue Shield pays and the amount billed by non-network hospital provider. It is therefore to the member’s advantage to obtain medical and hospital services from preferred hospital providers.

PPO Primary Care Physician Requirement for IFP PPO Members

Beginning in 2017, all individual and family plan (IFP) PPO benefit plan members, with the exception of IFP PPO grandfathered plan members, will be required to have a primary care physician (PCP) of record. This requirement is intended to encourage support and close collaboration between PPO patients and their primary care physicians, and to provide consistent partnership in maintaining preventive care and making informed decisions about specialty care when it is needed. The requirement for an assigned PPO PCP has been implemented by Covered California for all PPO individual and family plans offered through the Exchange. Blue Shield agrees with this approach and will apply the requirement to all IFP PPO plans, with the exception of grandfathered plans.

Blue Shield will assign a participating physician in the Exclusive PPO Network to each IFP PPO member. Physicians may opt out of eligibility to be assigned as a PCP.

The following criteria will be used to help determine which physicians are eligible for assignment:

- IFP PPO members who have already established an ongoing primary care relationship with an eligible PCP will be matched to that physician and appear in Blue Shield’s records as that member’s PCP.

- In order to be eligible for matching, an Exclusive PPO Network physician must practice within the specialties of Family Practice, Internal Medicine or Pediatrics. In addition, Blue Shield will apply other business rules to determine a physician’s eligibility to be assigned as a PCP to an IFP PPO member. For example, a physician practicing solely in an urgent care clinic or emergency room would not be among those eligible to be matched with a Blue Shield IFP PPO member as their PCP.
Blue Shield PPO Plans (cont’d.)

PPO Primary Care Physician Requirement for IFP PPO Members (cont’d.)

- A physician who does not wish to be assigned as a PCP to an IFP PPO member may opt out of eligibility for assignment by providing a written notification to Blue Shield, using one of the following methods:

<table>
<thead>
<tr>
<th>Method</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Email</td>
<td><a href="mailto:BSCPrvdrInformationEnrollment@blueshieldca.com">BSCPrvdrInformationEnrollment@blueshieldca.com</a></td>
</tr>
<tr>
<td>FAX</td>
<td>Provider Information and Enrollment (916) 350-8860</td>
</tr>
<tr>
<td>Postal mail</td>
<td>Provider Information and Enrollment P.O. Box 629017 El Dorado Hills, CA 95762-9017</td>
</tr>
</tbody>
</table>

Point-of-Service (POS) Plans

The POS plans combine both HMO and PPO service delivery features. At the time services are needed, or at the point of service, the member may choose to receive benefits under the HMO network or PPO network option. Under the latter option, the member may receive covered services from either a Blue Shield preferred hospital provider or non-network hospital provider. The choice determines the member’s level of financial responsibility.

Point of Service (POS) Options

<table>
<thead>
<tr>
<th>Network</th>
<th>How Care is Accessed</th>
<th>Financial Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMO Network</td>
<td>Member’s care is coordinated through the primary care physician who makes any necessary specialist referrals.</td>
<td>Physician and hospital services: Applicable HMO office visits and other copayments apply. No deductible unless the plan has a facility deductible which would be applied for applicable inpatient admissions.</td>
</tr>
<tr>
<td>PPO In-network</td>
<td>Member self-refers to a Blue Shield Preferred Provider.</td>
<td>Applicable PPO copayment and deductible applies.</td>
</tr>
<tr>
<td>Non-Network PPO (non-preferred or non-participating)</td>
<td>Member self-refers to a non-network provider.</td>
<td>Applicable PPO copayment and deductible applies. Member may be balance-billed.</td>
</tr>
</tbody>
</table>

Upon enrollment in the POS Plan, all members must select a primary care physician (PCP). Services rendered by the PCP or specialist and facility care authorized by the PCP are deemed to be provided under the HMO option. Facility claims for such HMO options should be submitted on a UB 04 (or successor) form.

Services provided on a “self-referred” basis – either by a physician who is not the member's PCP, by a specialist, or other provider without a referral from the member's PCP – will be paid according to the provider’s agreement with Blue Shield.

When hospital services are provided under the PPO option, the facility should use the UB 04 (or successor) form for submitting a claim, mark it "self-referred" and send it to the appropriate Service Center. Blue Shield physicians should admit patients to a select or preferred hospital and follow the PPO pre-admission guidelines (refer to Section 3: Medical Care Solutions).
Federal Employee Program (FEP)

About the BlueCross and BlueShield Service Benefit Plan

The local BlueCross and BlueShield Plans underwrite and administer the BlueCross and BlueShield Service Benefit Plan, the largest privately underwritten health insurance contract under the Federal Employee Health Benefits (FEHB) Program. Sixty-four percent of all federal employees and retirees who receive their health care benefits through the government’s FEHB Program are members of the Service Benefit Plan.

Federal Employee Program (FEP) Preferred Providers include Blue Shield’s Preferred Physicians and Blue Cross’ Preferred Hospitals. FEP members may select the Basic Option or Standard Option benefit level. Under the Standard Option, members can seek care from any covered provider they want, however, in some cases, they must get advance approval of care from Blue Shield. The Blue Cross Blue Shield Service Benefit Plan Brochure is located at FEPBlue.org as well as medical and medication policies. Important FEP phone numbers are as follows:

- Blue Shield of California FEP Customer Service (800) 824-8839.
- Blue Shield of California FEP Integrated Care Management (800) 995-2800
- Blue Shield of California FEP Utilization Management ad Prior Authorization (800) 633-4581
- Anthem Blue Cross FEP Customer Service (800) 322-7319

Under the Basic Option, members must use Preferred providers in order to receive benefits, except under the following special circumstances:

- Medical emergency or accidental injury care in a hospital emergency room and related ambulance transport as described in Section 5(d) Emergency services and accidents
- Professional care provided at preferred facilities by non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons
- Laboratory and pathology services, X-rays and diagnostic tests billed by non-preferred laboratories, radiologists and outpatient facilities
- Services of assistant surgeons
- Special provider access situations
- Care received outside the United States and Puerto Rico

Unless otherwise noted above, when services of non-preferred providers are covered in a special exception, benefits will be provided based on the plan allowance. Members are responsible for the applicable coinsurance or copayment and may be responsible for any difference between Blue Shield’s allowance and the billed amount.

Note: Please refer to Section 3 of the Blue Cross and Blue Shield Service Benefit Plan Contract Brochure for more information on special circumstances.
Federal Employee Program (FEP) (cont’d.)

Precertification for Inpatient Hospital Admissions

Preferred providers are responsible for obtaining pre-certification for all inpatient admissions to preferred hospitals. Pre-certification requires notification prior to scheduled admissions or within two business days after an emergency admission, even if the member has been discharged from the hospital within those 2 days. The member will be subject to the $500 benefit reduction if admitted to a preferred hospital and pre-certification is not obtained. The member is ultimately responsible for ensuring that pre-certification has been completed. If the pre-certification is not obtained, the member’s inpatient hospital benefit for covered services will be reduced by $500. (For specific rules, please refer to Section 3 the Blue Cross and Blue Shield Service Benefit Plan Contract Brochure located at Fepblue.org). Pre-certification is not needed for a maternity admission for pre-certification of additional days for the baby. The subscriber must add the baby to the plan before certification for services to be provided.

Mental Health, Substance Abuse, and Behavioral Health Services for FEP

It is important to follow these policies to help ensure your patient’s needs for mental health services are met efficiently. Please use the following information to request assistance:

- For any services that are to be rendered in a residential treatment center (RTC), please call (800) 995-2800 before services are rendered. Services in an RTC are a covered benefit, when medically necessary, for members who are enrolled and actively participating in the integrated care management program at Blue Shield. A case manager will be able to assist you and the member to develop a plan that meets the member’s needs.

- For Behavioral Health Inpatient Hospitalizations call (800) 633-4581. If the admission is emergent due to a condition that puts the member’s life in danger or could cause serious damage to bodily function, the member, the member’s representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if the member has been discharged from the hospital. If we are not telephoned within two business days, a $500 penalty may apply.

No prior authorization is required for outpatient professional services, including individual or group therapy, outpatient partial hospitalizations, intensive outpatient programs, office and home visits for FEP PPO members. If you should have any questions regarding coverage, please call FEP Customer Service at (800) 824-8839. If you have questions regarding prior authorization call FEP Prior Authorization department at (800) 633-4581.

Required Prior Authorization

Members must obtain prior approval for these services under both the Standard and Basic Option. Precertification is also required if the service or procedure requires an inpatient hospital admission. Contact Blue Shield at the prior authorization number at (800) 633-4581 before receiving these types of services. Find more information about the services below in the BCBSA Service Benefit Plan (SBP) Brochure at www.fepblue.org/benefit-plans/benefit-plans-brochures-and-forms.
<table>
<thead>
<tr>
<th>Prior Approval is required for:</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient sleep studies performed outside the home</strong></td>
<td>Prior approval is required for sleep studies performed in any other location that is not the member’s home.</td>
</tr>
<tr>
<td><strong>Applied behavior analysis (ABA)</strong></td>
<td>Prior approval is required for ABA and all related services, including assessments, evaluations, and treatments.</td>
</tr>
<tr>
<td><strong>Gender reassignment surgery</strong></td>
<td>Prior to surgical treatment of gender dysphoria, the provider must submit a treatment plan including all surgeries planned and the estimated date each will be performed. A new prior approval must be obtained if the treatment plan is approved and is later modified. Modification can be to the type of treatment, date, time or location of the service/surgery to be provided.</td>
</tr>
</tbody>
</table>
| **BRCA testing and testing for large genomic rearrangements in the BRCA1 and BRCA2 genes** | Prior approval is required for BRCA testing and testing for large genomic rearrangements in the BRCA1 and BRCA2 genes whether performed for preventive or diagnostic reasons. 
*Note:* Genetic counseling and evaluation services are required before preventive BRCA testing is performed. |
| **Surgical services** | Morbid Obesity - See the 2018 Service Benefit Plan Brochure for requirements. Surgical correction of congenital anomalies (see definition in the Service Benefit Plan Booklet); and surgery needed to correct accidental injuries to jaws, cheeks, lips, tongue, roof and floor of mouth (see definition in the Service Benefit Plan Brochure). Separate Inpatient (IP) Authorization is needed for all IP admissions. |
| **Hospice care** | Prior approval is required for home hospice, continuous home hospice, or inpatient hospice care services. Blue Shield will advise you which home hospice care agencies we have approved. Please contact FEP Care Management at (800) 995-2800. |
| **Organ/tissue transplants – Prior approval is required for both the procedure and the facility** | Covered Organ/tissue Transplants - See the list of covered transplant services in the 2018 Service Benefit Plan Brochure. 
If you travel to a Blue Distinction Center for Transplants, prior approval is also required for travel benefits. 
The organ transplant procedures must be performed in a facility with a Medicare-Approved Transplant Program. If Medicare does not offer an approved program for a certain type of organ transplant procedure, this requirement does not apply, and you may use any covered facility that performs the procedure. 
The blood or marrow stem cell transplants listed must be performed in a facility with a transplant program accredited by the Foundation for the Accreditation of Cellular Therapy (FACT), or in a facility designated as a Blue Distinction Center for Transplants or as a Cancer Research Facility. 
Clinical trials for certain blood or marrow stem cell transplants – See the list of conditions covered only in clinical trials in the 2018 Service Benefit Plan Brochure. |
Prior Approval is required for: | Additional Information
--- | ---
Prescription drugs and supplies | Contact CVS Caremark, our Pharmacy Program administrator, at (800) 624-5060 (TTY: 800-624-5077 for the hearing impaired) or visit the FEP CareMark website at: [https://www.caremark.com/wps/portal/WEBSUPPORT_FAQS?cms=CMS-PWCM-2034779](https://www.caremark.com/wps/portal/WEBSUPPORT_FAQS?cms=CMS-PWCM-2034779) to request prior approval, or to obtain a list of drugs and supplies that require prior approval.
Please note that updates to the list of drugs and supplies requiring prior approval are made periodically during the year. New drugs and supplies may be added to the list and prior approval criteria may change.

Mail Order Prescription Drug Program | Standard Option members may use our Mail Service Prescription Drug Program to fill their prescriptions. Basic Option members with primary Medicare Part B coverage also may use this program once prior approval is obtained.

Medical foods covered under the pharmacy benefit | Contact CVS Caremark, our Pharmacy Program administrator, at (800) 624-5060 (TTY: 800-624-5077 for the hearing impaired) to request prior approval.
Federal Employee Program (FEP) (cont’d.)

Integrated Care Management Program for FEP

Nurses who are licensed and familiar with California resources will be assisting your patients with obtaining the resources they require to maintain their optimum health. The referral phone number is (800) 995-2800.

Our Integrated Case Management program offers a systematic application of processes and shared information to optimize the design and coordination of benefits and care for members identified with acute or complex conditions. Through comprehensive, high-touch, coordinated care management delivered in partnership with providers, clients, and members, the program promotes improved health outcomes, quality of life, and member satisfaction.

Conditions managed through our Integrated Case Management Program include:

- **Acute Catastrophic** – Includes members with immediate needs relating to an acute episode of care for conditions such as stroke, sepsis, spinal cord injury, trauma, amputation, open wounds, newly diagnosed cancer, or complications from surgeries characterized by readmission to the hospital.

- **Disease Management** – Blue Shield provides disease management services to our members identified with chronic medical conditions, such as; Asthma, Diabetes, CHF, Chronic Obstructive Pulmonary Disease (COPD) and Coronary Artery Disease (CAD). Chronic diseases, including cardiovascular disease and diabetes, are the leading causes of death in California and are among the most common, costly and often preventable of health problems. Disease management is an approach to reach members with chronic conditions and provide them with the necessary tools to minimize the impact of their condition.

- **Post-neonatal Intensive Care Unit (NICU)/Pediatrics** – Focuses on premature or medically complex neonates being discharged home from the hospital after birth, as well as pediatric members with special needs.

- **Behavioral Health** – Assists members with Mental Health and Chemical Dependency diagnosis. Participates in discharge planning for all inpatient psychiatric and substance abuse admissions, including detoxification.

- **Oncology** – Focuses on members with cancer diagnoses to manage them through the health care continuum.

- **Palliative Care** – Provides a care management option for patients that includes symptom control in addition to curative therapy. A combination of palliative care while curative care is ongoing has been shown to improve quality of life, reduce inpatient stays, increase choice of hospice and the results have been demonstrated in both a care delivery locus and in a health plan setting. The intent of the program is to permit the use of palliative care, for severe chronic conditions one year in advance of the patient’s likely end of life.
Federal Employee Program (FEP) (cont’d.)

Transitions of Care Program for FEP

Blue Shield’s Transitions of Care program focuses on members and caregivers who need guidance on the transition to and from hospital and home. Unplanned readmissions are prevented by completing a safety risk assessment with the member, discussing follow-up plans, medication reconciliation, and facilitating adherence to the prescribed treatment plan. Length of hospital stay is decreased by preparing member for hospital stay and development of a discharge plan. The referral phone number is (800) 995-2800.

The Transitions of Care program has four primary components:

- A telephone call to the member by a Transitions of Care Nurse (TCN) to discuss the surgery/acute condition, what to expect, what to ask their physician, and how to prepare for the return home.

- A complimentary Guided Imagery Toolkit mailed to members prior to or following surgery that contains an instructional letter and an audio tape or compact disc of recordings that weave together inspirational music, healing images, and positive statements to help add to a member’s sense of safety and comfort prior to and following surgery.

- A recovery guide that provides members with useful information regarding what to ask their physician such as pre- and post-operative testing and preparation, expected post-operative recovery milestones, and information regarding return to work.

- A post-hospitalization call to identified patients who are urgently or emergently admitted to an acute care hospital. The TCN will discuss adherence to the discharge plan, provide medication reconciliation, and conduct a needs assessment for any unmet needs the patient may have post discharge. Additionally, the TCN may engage in care coordination efforts with the member when any unmet needs that have been identified that may need further intervention.
Medicare Supplement Plans

Claims Assignment

For physician providers who accept assignment, Blue Shield pays contract benefits up to Medicare's approved amounts. Patients are responsible for payment of services not approved by Medicare. For physician providers who do not accept assignment, Blue Shield will pay according to the following structure for Medicare Supplement Plans and Group plans:

<table>
<thead>
<tr>
<th>Plan and Group Numbers</th>
<th>Medicare Unassigned Claims</th>
</tr>
</thead>
</table>
| **Benefit Plan A, B, C, D, H, K**  
  Group #s SAS, SBS, SCS, SDS, SHS, SHR, SKS | Blue Shield pays contract benefits.  
  Patients pay balance of billed charges (limiting charge).* |
| **Benefit Plan F, I, J**  
  SFS, SIS, SIR, SJS | Blue Shield pays 100% of the difference between Medicare's payment and billed charges. |
| **Benefit Plan G**  
  Group #s SGS | Blue Shield pays 80% of the difference between Medicare's payment and billed charges. Patients pay balance of billed charges.* |
| **Golden Coronet Senior**  
  500915-500918, 520915-520918 | Blue Shield pays 80% of the difference between Medicare's payment and billed charges. Patients pay balance of billed charges.* |
| **Coronet Major Medicare**  
  500921-500922, 500923-500924 | Blue Shield pays contract benefits.  
  Patients pay balance of billed charges.* |
| **Coronet Senior**  
  500913-500914, 520913-520914, 500927-500928, 520927-520928, 550913-550914, 550927 | Blue Shield pays contract benefits. Patients pay balance of billed charges.* |
| **Preferred Senior**  
  PS2901, PS2902, PS2911, PS2912 | Blue Shield pays contract benefits. Patients pay balance of billed charges.* |

*Not to exceed the Medicare limiting charge or billed charge, whichever is less.

**Note:** Preferred Senior contracting physicians agree to accept Medicare assignment for Preferred Senior Plan members. Contracting Preferred Senior Anesthesiologists bill the Preferred Senior Plan directly under the Advance Pay System.
The BlueCard® Program

The BlueCard® Program is a national program that enables Blue Cross and Blue Shield (BCBS) Plan members to obtain healthcare services while traveling or living in another Blue Cross and/or Blue Shield Plan’s service area. The program links participating healthcare providers with all the independent Blue Cross and Blue Shield Plans across the country through a single electronic network for claims processing and reimbursement. Additionally, the program links providers in more than 200 countries and territories worldwide.

The BlueCard Program allows providers to conveniently submit claims for members from out-of-state Blue Plans, including international Blue Plans, directly to Blue Shield of California. Blue Shield offers you a one-payor solution for submitting your BlueCard claims, and a point of contact for your claims-related questions, through the convenience of Blue Shield.

For more detailed information about the BlueCard Program, refer to Appendix 5-A of this manual or access the BlueCard Program web page at www.blueshieldca.com/bluecard.

Other Payors

Blue Shield and its affiliates may contract with employers, insurance companies, associations, health plans, health and welfare trusts or organizations, other payors, and administrators (collectively, “Other Payors”) to provide administrative services for plans provided by those entities which are not underwritten by Blue Shield. Such administrative services may include offering access to the physician and provider networks under contract to Blue Shield or its affiliates. In general, Other Payors must meet financial and administrative criteria established by Blue Shield, and their health programs must encourage the use of contracting providers. In the event that Blue Shield is not the underwriter of the health plan, the Other Payor shall be responsible for payment or covered services. Refer to Appendix 5-B for the Other Payor Summary list.

Blue Shield or its affiliates may adopt the policies and procedures of the Other Payors for services rendered for these members. Claims for Other Payors’ members should be sent according to the manuals or the member ID cards, which will generally identify where claims are to be submitted. Providers must look solely to the Other Payor for payment for covered services rendered to Other Payors’ members (except for copays, coinsurance and deductibles which may be collected from members). Payments and allowances will be clearly shown on the Other Payors’ Explanation of Benefits (EOBs).
Mental Health Services

Psychiatric Care

The diagnosis and medically necessary treatment of mental health conditions are a covered benefit for all Blue Shield plans. Severe mental illness and serious emotional disturbances of a child for all commercial members are covered under the same terms and conditions as any medical condition. Blue Shield’s mental health service administrator (MHSA) for commercial PPO members is Human Affairs International of California (HAI-CA). Other psychiatric conditions are also covered through the MHSA.

Members must utilize the Blue Shield MHSA provider network to access psychiatric covered services and receive authorization for these services from the MHSA.

Commercial PPO members should use the Member Self-Referral phone number below to contact Blue Shield’s MHSA to access behavioral health care.

Member Self-Referral Number

Blue Shield members can self-refer to the MHSA by calling the Member Self-Referral Number at (877) 263-9952 to obtain a referral to an appropriate mental health provider and receive an authorization for services and/or crisis intervention services. This phone number is available 24 hours/day; 7 days per week, 365 days a year.

Primary Care Physician Consultation Line

The Blue Shield MHSA offers a Primary Care Physician Consultation Line at (877) 263-9870 to facilitate Personal Care Physician discussion with a Board-Certified psychiatrist regarding mental health and substance abuse issues, prescribing of psychotropic medication and coordination of care issues.

PCP Behavioral Health Toolkit

Primary care physicians and their staff members can access Blue Shield’s new online PCP Behavioral Health Toolkit at any time by visiting blueshieldca.com/provider, selecting the Guidelines & Resources tab, then clicking PCP Behavioral Toolkit under the Patient Care Resources section. The website includes clinical consultation contacts, referral information, screening tools, patient education resources and more to help primary care physicians manage or refer patients to meet behavioral health care needs.

Telebehavioral Health Online Appointments

The Blue Shield MHSA offers real-time, two-way communication via online virtual appointments with a mental health or substance use disorder provider. Appointments are available for counseling services, psychotherapy, and medication management with participating therapists and psychiatrists contracted with Blue Shield’s mental health service administrator (MHSA). To access Telebehavioral health providers, members can visit Find a Doctor on blueshieldca.com. Once on Find a Doctor, click on Mental Health to be directed to Blue Shield’s MHSA website. Enter the required search criteria, hit search and on the next screen click on More Filters, then select Telebehavioral Health from the Specialties drop down list.
Mental Health Services (cont’d.)

Blue Shield MHSA Covered Services for PPO Commercial Plan Members

Blue Shield’s MHSA is responsible for authorizing services and paying claims for the following services:

- In-network professional and institutional psychiatric services.
- Pre-surgical Psychiatric/Psychological evaluations requested by the surgeon.
- Outpatient services for the treatment of mental health diagnoses when provided by a MHSA contracted clinician.
- Electro-convulsive Therapy (ECT) and associated anesthesia.
- Behavioral Health Treatment (BHT) including Applied Behavior Analysis (ABA).
- Inter-facility transports authorized by the MHSA.
- Psychological testing for a psychiatric condition.

For the following other services, please see member’s health plan benefits:

- Outpatient radiology, laboratory, speech therapy, occupational therapy, and physical therapy services associated with a psychiatric diagnosis.
- Medical consultations requested by the MHSA.
- Structured Pain Management Program.
- Nutritional counseling.
- Experimental or investigational treatments.
- Outpatient prescription medications.

Mental Health Services for Self-Funded Accounts (ASO) and the Federal Employee Program (FEP)

Self-Funded Accounts (ASO) and the Federal Employee Program (FEP) use Blue Shield of California’s network of contracted mental health providers. Claims are billed to Blue Shield.

For additional mental health information for ASO and FEP accounts, see the following sections within this manual:

- Section 2: Behavioral Health Requirements – FEP PPO and ASO
- Section 3: Mental Health and Substance Use Disorder Clinical Management Program for Self-Insured Accounts (ASO)
- Section 5: Federal Employee Program (FEP); Mental Health, Substance Abuse, and Behavioral Health Services for FEP
Blue Shield Benefit Programs

Care Management

Shield Support is Blue Shield’s comprehensive, integrated care management program that includes member-focused clinical interventions to optimize health and quality of life. The program offers a personalized, coordinated approach to care, encouraging members to be active participants in the management and improvement of their own health. Through shared decision making and a whole-person approach, the goal is for each member to receive care that is customized to their specific needs and preferences.

The Shield Support experienced care teams include registered nurses, behavioral health clinicians, social workers, dietitians, physicians and pharmacists who provide long and short-term support, including:

- **Case management** for acute, long-term, and high-risk conditions, designed to help members live better with illness, recover from acute conditions, and develop self-management skills
- **Care coordination** services to help members navigate the healthcare system and access care, and to facilitate information sharing among the healthcare team involved in the member’s care

Through skilled interviewing, the care team empowers members to take action and choose their own health goals. A personalized care plan is developed to help ensure that member needs and preferences are known and communicated. The care team maintains frequent contact with members, their caregivers, and providers in order to help assure the provision of safe, appropriate and effective care and provides support by coordinating the wide range of specialized care from numerous providers to help prevent duplicate or unnecessary treatments and tests. The care team also provides coaching on medical conditions as well as behavioral health support and lifestyle modifications for an optimal quality of life.

The Shield Support care team works to prevent readmissions by completing safety risk assessments, discussing follow-up care plans, reconciling medication and facilitating adherence to prescribed treatment plans. Shield Support prepares members in advance for hospital stays, including guided imagery recordings to assist members in preparing for surgery or dealing with other health issues. The program is supported by medical directors who provide clinical direction and oversight to the care team.

Shield Support is designed to allow the member to better manage their medical treatment, their health conditions, and the many related issues that may impact their quality of life.

Member identification for Shield Support is based on our customized predictive risk score. This predictive risk score was developed to optimize outreach to those members who are likely to become high risk and are most likely to benefit from care management support. Additionally, condition specific triggers and utilization patterns are used to identify members for Shield Support.
Care Management (cont’d.)

Members may also be identified from an acute event or hospital admission or discharge. Shield Support encompasses a broad spectrum of interventions for short-term care coordination as well as ongoing complex case management for members with the following conditions or utilization:

- Behavioral health
- Cancer
- Cardiovascular, e.g., Coronary Artery Disease, Heart Failure
- Catastrophic injury
- Diabetes
- Musculoskeletal
- Chronic Pain
- Respiratory, e.g., Asthma, COPD
- End-stage renal disease
- Stroke
- Transgender
- Transplant (solid organ and bone marrow)
- Pre-term infants in the Neonatal Intensive Care Unit (NICU) and post NICU
- Plus: ER utilization, post-discharge from hospital, opioid use, high cost and direct referrals

The following services are offered through the Shield Support program:

- Telephonic coaching from nurses, behavioral health clinicians, social workers and pharmacists
- Home visits (as needed)
- Biometric home monitoring (for some members with diabetes, coronary artery disease, COPD, and heart failure)
- In-person self-management community workshops (for members 18+ years of age)
- Virtual health coaching and cognitive behavioral therapy modules
- Online self-management workshops and educational materials (for members 18+ years of age)

Physician referrals are an important component of Blue Shield’s Care Management Programs and may allow for identification of a member more quickly. Blue Shield providers may refer Blue Shield members to our Care Management Programs by submitting the referral form via secure email to bscliaison@optum.com or fax to (877) 280-0179. To download an electronic copy of the referral form, please visit www.blueshieldca.com/provider/guidelines-resources/patient-care/programs.sp. Each referral will be evaluated for eligibility and appropriateness
Care Management (cont'd.)

In addition to Shield Support, the following discrete Prenatal case management program is offered:

- **Prenatal Program.** This program is designed to improve the quality of care received before and during pregnancy and to reduce the costs associated with high-risk pregnancies, while helping women have healthy pregnancies and healthy babies.

**Additional Care Management Programs**

The following programs are available to certain Blue Shield members depending on their plan design:

- **Shield Advocate.** The Shield Advocate program provides a designated team of registered nurses to a client's membership to provide a proactive, member-focused approach to navigate the healthcare system, resolve problems, answer health and treatment related questions, provide health counseling, and support coordination of care.

- **Shield Concierge.** Shield Concierge is an integrated service designed to provide a customer-specific, personalized service experience for members covered by Blue Shield. This program strives to improve and expand the member experience by resolving more inquiries during the first contact with the member and proactively identifying services specifically beneficial to the member. A team of professionals consisting of Shield Concierge representatives, registered nurses, social workers, health coaches, pharmacy technicians, and pharmacists provide information to a member regarding benefits, doctors and specialists, coordination of care, case management, and questions on formulary and drug authorizations.

- **Expanded Managed Behavioral Health.** Administered by Blue Shield’s Mental Health Service Administrator (MHSA), the Expanded Managed Behavioral Health program provides a sophisticated approach to managing inpatient and outpatient behavioral health services. The program employs specially trained behavioral health clinicians to assess a member’s situation and direct him/her to the most appropriate care setting.

- **Landmark Home-Based Care.** The Landmark program offers participating chronically ill members 24/7 access to medical professionals and in-home urgent care. Community-based, physician-led medical teams specializing in house calls and home-based care deliver medically needed services to chronically ill patients. Landmark does not replace patients’ primary care providers but rather supports the work of patients’ existing providers. Landmark clinicians communicate and collaborate with the patients’ PCPs and specialists to reinforce the PCP’s in-office care plan and provide the attention and care that chronically ill patients with complex health needs may require. Blue Shield identifies eligible members for the Landmark program based on their health and the number and type of chronic conditions they have.
Home-Based Palliative Care Program

Blue Shield offers a home-based palliative care program that uses an interdisciplinary team to provide tightly integrated, longitudinal in-home palliative care services as well as the assessment and provision of medical care aligned with the patient’s goals. The program incorporates:

- treatment decision support,
- care plan development and shared decision-making, and
- pain and symptom management.

Services provided under the program include, but are not limited to:

- comprehensive in-home, palliative care needs assessment,
- care plan development aligned with the member’s goals,
- nurse case manager assignment to coordinate medical care,
- home-based palliative care visits - either in person or via videoconferencing,
- medication management and reconciliation,
- psychosocial support for mental, emotional, social and spiritual well-being,
- 24/7 telephonic support,
- caregiver support, and
- transition assistance across care settings (Note: A member remains enrolled in the program during admission to and discharge from any facilities where the member seeks care).

Members do not need to be terminal nor forego curative treatment to qualify for the program. Members most likely to benefit from the program include those in remission, recovering from serious illness or in the late stage of illness; those experiencing documented gaps in care including a decline in health status and/or function; and those using the hospital and/or the emergency room to manage illness/late-stage disease.

Eligibility/Referral

The home-based palliative care program is available to all Blue Shield members except for those covered under a PPO Federal Employee Plan (FEP), a Blue Shield Medicare supplemental insurance plan (Medigap), or those currently enrolled in hospice or who have an illness that is primarily a psychiatric or substance use disorder. Members with one of the following diagnosis categories, among others, are appropriate for the program: cancer, organ failure, stroke, neurodegenerative disease, HIV/AIDS, dementia/Alzheimer’s, frailty or advance age, and/or multiple comorbidities.

Referral to the program can be made in one of three ways: (1) members can self-refer to the program by contacting Blue Shield Member Customer Service at the phone number located on the back of the member ID card, (2) medical care providers can refer members to the program by contacting Blue Shield Provider Customer Service at (800) 541-6652, or (3) Blue Shield case managers can refer members to the program.

Once a referral is made, the member will be screened to determine whether or not the criteria outlined in the Palliative Care Patient Eligibility Screening Tool (see Appendix 2) is met, then the member can decide whether or not to participate in the program. Enrollment in the program does not eliminate nor reduce any covered benefits or services, including home health services.
Wellness and Prevention Programs

Blue Shield offers member-directed health improvement programs. Our mission is to support a member’s access to high quality care and facilitate participation in managing his or her own health. Blue Shield actively encourages providers to become familiar with these programs so they can assist members in learning about and taking advantage of these services. Blue Shield offers the following preventive health and wellness initiatives:

CareTips Clinical Messaging

CareTips is a clinical messaging program designed to help improve quality of care and yield cost-of-healthcare savings. Members receive CareTips communications that are based on nationally-recognized clinical practice guidelines and focus on quality improvement topics, many of which are drawn from HEDIS clinical measures. CareTips messages are derived from a systematic analysis of Blue Shield’s medical, pharmacy, and lab claims that identifies potential gaps in care and medication-related issues.

The messages are intended to encourage preventive care and support improvement in treatment outcomes for patients with chronic conditions. We encourage members to bring these communications to their provider for further discussion and possible coaching and follow up.

Daily Challenge

Members can take a small step each day on the path to better health with our engaging interactive program, Daily Challenge. Signing up is easy at www.mywellvolution.com. Every day members get an email to perform one simple wellness-related task. The Daily Challenge is mobile; users can receive their challenges via email, SMS text, mobile app, or the web platform. They can earn points, connect with others, and build a support network with friends and family as they explore techniques to improve all areas of their well-being. Taking a confidential Well Being Assessment is easy and helps members focus in the areas of their well-being that they most want to improve.

Diabetes Prevention Program (DPP)

The Diabetes Prevention Program helps members who are at risk of type 2 diabetes lose weight and adopt healthy habits. The program includes 16 weekly sessions over the span of six months followed by monthly maintenance sessions during which members learn new ways to eat healthier, increase activity, and manage challenges with help from a personal health coach and small support group. The program is digital or in-person. Members can get started by pre-qualifying at www.solera4me.com/shield.
Wellness and Prevention Programs (cont’d.)

LifeReferrals 24/7SM

A phone call connects members with a team of advisers who can help them with personal, family, and work issues. They’ll be guided to the appropriate professional, depending on their needs. Some of the services offered are:

- **Legal and financial** – Members can connect with a financial adviser on money matters or an attorney on a variety of legal services. Members may be eligible to receive a 60-minute consult at no cost to them.

- **Personal challenges including relationship problems or coping with grief** – Members can talk to a referrals specialist and set up face-to-face sessions with licensed therapists at no cost to them.

- **Work/life resources** – Members can consult with a specialist who can provide useful information and referrals to a wide range of resources, such as educational programs, day care, meal programs, transportation, and more.

The LifeReferrals 24/7 team is available to discuss your patients’ concerns and guide them to possible solutions anytime, day or night, at (800) 985-2405. All of the services and referrals to resources are treated confidentially.

Blue Shield offers information on a broad range of services that help members manage the impact of home, health and career. These include:

- **Adult and Elder Support Services** – Help with aging parents and family, including in-home and long-term care, transportation, and housing.

- **Child and Parenting Support Services** – Resources for meeting parenting challenges, day care, tutoring, pregnancy, adoption, and child development.

- **Family and Relationship Services** – Information to help deal with parent-child conflicts, single parent challenges, and better communication.

- **Lifelong Learning** – Information about schools, classes, and other opportunities for growth.

- **Financial Assistance** – Consultations with financial advisers on money matters.

- **Legal Assistance** – Consultations and discounts on a variety of legal services.

- **Domestic Relocation** – Resources and support for members moving into a new community.
Wellness and Prevention Programs (cont’d.)

NurseHelp 24/7℠

Members can access a registered nurse anytime, day or night, seven days a week, 365 days a year at no cost by phone at (877) 304-0504 or online, www.blueshieldca.com. Experienced nurses are ready to answer questions, listen, and provide members with information that can help them choose the most appropriate level of care for their situation. The nurses are trained to offer callers:

- **Health information** – Better understanding of health concerns and chronic conditions, education about possible treatment options to help patients make informed decisions and suggestions for preparing for doctor appointments.

- **Healthcare assistance** – Guidance in understanding and choosing the most appropriate types of health care such as hospital, urgent care center, doctor visit, or home treatment. Assistance with questions about medical tests, medications and living with chronic conditions.

- **Preventive and self-care measures** – Helpful tips for taking care of minor injuries at home, such as a twisted ankle or a common illness like a cold or the flu.

- **Online nurse help** – One-on-one personal Internet dialogue with a registered nurse 24 hours a day, seven days a week. Members get immediate answers to their general health questions and research assistance. The online nurses can also refer members to health information, resources and member programs on blueshieldca.com.

LifeReferrals 24/7 and NurseHelp 24/7 are designed to complement, not replace, the care you provide to your patients.

**Preventive Health Guidelines**

Blue Shield’s Preventive Health Guidelines are based on nationally recommended guidelines for screening examinations, immunizations, and counseling topics for healthy individuals, as well as for individuals at risk for disease. These guidelines are updated and distributed annually to members via blueshieldca.com. Clinical reference sources include the US Preventive Services Task Force (USPSTF) Guide to Clinical Preventive Services, American Academy of Pediatrics, the Advisory Committee on Immunization Practice, and the Health Resources and Services Administration Women’s Preventive Services Guidelines.

Guidelines available in both English and Spanish are located on Provider Connection at blueshieldca.com/provider under Eligibility & Benefits, then Preventive Health Guidelines.
Wellness and Prevention Programs (cont’d.)

Preventive Health Services Policy

Blue Shield has developed a Preventive Health Services Policy as a result of the Affordable Care Act (ACA) of the health reform legislation, adopting United States (US) Preventive Services Task Force (USPSTF) recommendations; the US Department of Health and Human Services, Health Resources and Services Administration (HRSA) recommendations for infants, children, adolescents, and women; immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC); American Academy of Pediatrics/Bright Futures/Recommendations for Pediatric Preventive Healthcare; and additional requirements mandated by the state of California. This policy applies to new and renewing members.

These services, when criteria are met and the primary reason for the visit is preventive care, will be provided under the preventive care services benefits with no cost-sharing to the member when applicable procedure and diagnosis codes are billed together. When a preventive service is provided during a non-preventive visit, the entire visit will be provided under the medical benefit of the member’s plan, and cost-sharing may apply per member benefits.

The Preventive Health Services Policies are located on Provider Connection at blueshieldca.com/provider under Eligibility & Benefits, Preventive Health Guidelines, and then Preventive Benefit Policies.

QuitNet

QuitNet utilizes digital coaching, access to California quit line telephonic counselors, online community support, and complimentary doorstep delivery of nicotine replacement therapy for smokers looking to kick the habit. Member access is available via native app or website and participants are prompted daily via app, text, or email to engage with the platform, community and/or coaches. A number of clinical trials have been published documenting QuitNet’s clinical efficacy.

Walkadoo

Walkadoo provides daily personalized physical activity recommendations via app, text, or email. Utilizing third party fitness trackers (e.g., Fitbit, Jawbone, Misfit) or smartphone step tracking functionality allows Walkadoo to offer customized steps/day prescriptions based upon an individual’s actual physical activity patterns. A recently published trial reflected a significant improvement in steps/day among Walkadoo users compared to controls with particular impact among the high-risk sedentary and low-active populations.
Wellness and Prevention Programs (cont’d.)

Wellness Discount Programs

To make it easier for members to take care of themselves, Blue Shield offers a wide range of member discounts on popular programs that can help them save money while they get healthier, including:

- Weight Watchers – Discounts on monthly subscriptions and at-home kits.
- 24-Hour Fitness – Waived enrollment, processing, and initiation fees, as well as discounted monthly dues.
- ClubSport, and Renaissance ClubSport – Discounts on enrollment and complimentary personal training sessions.
- Alternative Care Discount Program – 25% savings on acupuncture, chiropractic services, and therapeutic massage services from practitioners participating with the ChooseHealthy® program. The program also allows you to get discounts up to 57% on popular products from health and fitness vendors. In addition, members can learn from evidence-based, online health classes and articles offered at no cost.
- LASIK surgery – Discounts on LASIK surgery through QualSight LASIK, and LASIK and PRK surgery through NVISION, Inc.
- Discount Vision Program – Discounts on vision exams, frames and lenses, contacts lenses, and more.

Patient Ally

Patient Ally at http://www.patientally.com is an Internet portal developed by Office Ally that lets Blue Shield providers and members view lab results, order prescription refills, request and schedule appointments, and more.

Providers can easily add this online communication tool to their practice in order to achieve greater levels of efficiency and patient satisfaction. Patient Ally is designed to work easily into providers’ daily routines. For more information or to register, visit http://www.officeally.com or call (888) 747-4255.