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
- Medicare Advantage Plans
- Point of Service (POS) Plans
- Federal Employee Program (FEP) PPO
- Medicare Supplement Plans
- The BlueCard® Program
- Other Payors
- Mental Health and Substance Use Disorder Services
- Ancillary Benefits

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+ Specialist℠ 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 Medicare Advantage Plans

Blue Shield's Medicare Advantage 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 a Blue Shield Medicare Advantage plan, have paid any premiums required for initial enrollment to be valid, and whose enrollment in a Blue Shield Medicare Advantage plan, has been confirmed by the Centers for Medicare & Medicaid Services (CMS). Blue Shield Medicare Advantage plans are 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 a Blue Shield Medicare Advantage plan program, the member must have both Medicare Part A and Medicare Part B and live within the CMS-approved Blue Shield Medicare Advantage plan service area. On May 22, 2020, CMS issued a Final Rule that permits enrollment of individuals with End Stage Renal Disease (ESRD) in MA-PD plans, effective January 1, 2021, as long as they meet the Medicare Advantage carriers' eligibility criteria.

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

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)).

Medicare Part D *(cont'd.)*

Part D Eligibility

In general, an individual is eligible to enroll in a MA-PD or PDP plan 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 MA-PD or 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 MA-PD or PDP sponsor may not deny enrollment to otherwise eligible individuals covered under an employee benefit plan. If the individual enrolls in a MA-PD or 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.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining.

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 list 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
- www.sam.gov

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 *(cont'd.)*

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; (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 or (c) Have been convicted of a felony under federal or state law within the previous 10 years that CMS deems 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 Covered Drug

A Part D covered drug is available only by prescription, approved by the Food and Drug Administration (FDA) (or is a drug described under section 1927(k) (2) (A) (ii) or (iii) of the Act), used and sold in the United States, and used for a medically accepted indication (as defined in section 1927(k) (6) of the Act). A covered Part D drug includes prescription drugs, biological products, insulin and medical supplies directly associated with delivering insulin to the body, including syringes, needles, alcohol swabs, gauze, and insulin injection delivery devices not otherwise covered under Medicare Part B as described in specified paragraphs of section 1927(k) of the Act, and vaccines licensed under section 351 of the Public Health Service Act. The definition of a covered Part D drug excludes any drug, biological product, insulin, or vaccine for which as prescribed and dispensed or administered to an individual, payments would be available under Parts A or B of Medicare for that individual. In essence, if the drug is administered to the member or dispensed within the four walls of a provider's office or facility, it is a Part B medication. CMS' understanding that the practice of "brown-bagging" drugs is opposed by medical societies. CMS continues to urge providers to reinforce this message to their members. The following drug categories are covered by Medicare Part B and therefore excluded from Part D:

Medicare Part D *(cont'd.)*

Medicare Part D Prescriber Preclusion List *(cont'd.)*

1) Any injectable or infusible drug that is defined by a Medicare contractor as usually not self-administrable (e.g., injectable chemotherapy) or
2) Any injectable or infusible drug that there exists a safety concern such that it would go against accepted medical practice for a particular injectable or infusible to be dispensed directly to a patient based on medical literature.

In addition, the definition of a covered Part D drug specifically excludes drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act. Medicare Part D establishes that the administration fee of a Medicare Part D vaccine is to be considered part of the Part D vaccine cost.

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:
    - Chronic Heart Failure (CHF)
    - Diabetes
    - Hypertension
    - Osteoporosis
    - Chronic Obstructive Pulmonary Disease (COPD)
- Receive seven or more different covered Part D maintenance medications 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

Medicare Part D *(cont'd.)*

Medication Therapy Management Program (MTMP) *(cont'd.)*

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 in network health care professional or facility is used.

A member's copayments and deductible amounts for covered services will vary depending on whether he or she selects an in-network health care professional or facility. Therefore, there is a financial incentive for members to use in network health care professionals and facilities.

If a member chooses to go to an out of network health care professional or facility, Blue Shield's payment for a service by that out of network health care professional or facility 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 out of network health care professionals and facilities. It is therefore to the member's advantage to obtain medical and hospital services from in network health care professionals and facilities.

The Virtual Blue PPO plan uses remote, digital engagement as the default care delivery method when appropriate. Members have access to virtual primary care and specialist care, including psychiatry and psychology. A care team consisting of a virtual PCP, health coach and behavioral health specialist help members get the care they need. When in-person care is either preferred by the member or referred to by the care team, members have access to both in network and out of network health care professionals and facilities as outlined above.

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.

Blue Shield PPO Plans *(cont'd.)*

PPO Primary Care Physician Requirement for IFP PPO Members

All individual and family plan (IFP) PPO benefit plan members are 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.

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.
- 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 Provider Information and Enrollment by email to BSCProviderInfo@blueshieldca.com or mail to P.O. Box 629017, El Dorado Hills, CA 95762-9017.

Blue Shield Medicare (PPO) (Medicare Advantage)

Blue Shield Medicare (PPO) is one of 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 Medicare (PPO), have paid any premiums required for initial enrollment to be valid, and whose enrollment in Blue Shield Medicare (PPO), has been confirmed by the Centers for Medicare & Medicaid Services (CMS). Blue Shield Medicare (PPO) 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 Medicare (PPO) program, the member must have both Medicare Part A and Medicare Part B and live within the CMS-approved Blue Shield Medicare (PPO) service area. On May 22, 2020, CMS issued a Final Rule that permits enrollment of individuals with End Stage Renal Disease (ESRD) in MA-PD plans, effective January 1, 2021, as long as they meet the Medicare Advantage carriers' eligibility criteria.

The Blue Shield Medicare (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 Medicare 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 provider or a non-network provider. Therefore, there is a financial incentive for members to use Blue Shield Medicare preferred providers.

The Blue Shield Medicare (PPO) plan is regulated by the Centers for Medicare & Medicaid Services (CMS), the same federal agency that administers Medicare. Please contact Blue Shield Medicare Customer Care (877) 654-6500 (for Providers), (800) 776-4466 (for Members), if you have questions about benefit information, eligibility, claims, and/or billing.

Blue Shield Medicare (PPO) Service Area

The definition of a service area, as described in the Blue Shield Medicare (PPO) *Evidence of Coverage* (EOC), is the geographic area approved by the CMS in which a person must permanently reside to be able to become or remain a member of a Blue Shield Medicare (PPO) plan. Blue Shield Medicare (PPO) has one service area within the state. The specific service area in which the member permanently resides determines the Blue Shield Medicare (PPO) plan(s) in which the member may enroll. Members who temporarily move outside of the service area (as defined by CMS as six months or less) are eligible to receive emergency care and urgently needed services outside the service area.

Individual Blue Shield Medicare (PPO) Service Areas

Alameda County
Orange County
San Diego County

Blue Shield Medicare (PPO) (Medicare Advantage) *(cont'd.)*

Blue Shield Medicare (PPO) Benefits

Premiums and Copayments or Coinsurance

Medicare Premiums

All Blue Shield Medicare (PPO) members (individual and group) must continue paying their Medicare Part B premium. The Medicare Part B premium is either deducted from their monthly Social Security or Railroad Retirement Board annuity check or is paid directly to Medicare by the member or someone on his/her behalf (i.e., the Medi-Cal program).

The Affordable Care Act requires Part D enrollees with higher income levels to pay a monthly adjustment amount, the Part D Income Related Monthly Adjustment Amount (IRMAA). This IRMAA applies to all Medicare beneficiaries, both group and individual, who fall into higher income levels. The Part D IRMAA is paid directly to the government and, like the Part B premium, may be deducted from the monthly Social Security or Railroad Retirement Board annuity check or paid directly to Medicare by the member or someone on his/her behalf.

Failure to pay either the Medicare Part B premium or Part D IRMAA will result in the member being involuntarily disenrolled from Blue Shield's Medicare Advantage plan, both individual and group.

Plan Premiums

Blue Shield Medicare (PPO) individual plans have a monthly plan premium. Please refer to the Blue Shield Medicare (PPO) individual *Summary of Benefits* for additional plan premium information.

The monthly plan premium for Blue Shield Medicare (PPO) group plans are determined through an actuarial-based pricing process and model which Underwriting uses to develop the rates. Plan premiums vary by employer group.

Copayments or Coinsurance

Blue Shield Medicare (PPO) members must pay a copayment or coinsurance for certain services. Please refer to the Blue Shield Medicare (PPO) individual or group *Summary of Benefits* for additional copayment or coinsurance information.

Pharmacy Copayments or Coinsurance

Copayment or coinsurance amounts vary by the Blue Shield Medicare (PPO) individual or group plan, as well as by the tier placement of the covered medication and whether the member obtains the medications from a network pharmacy with preferred cost-sharing, an out-of-network pharmacy, a network pharmacy with standard cost-sharing, or the mail service pharmacy.

Blue Shield Medicare (PPO) (Medicare Advantage) *(cont'd.)*

Blue Shield Medicare (PPO) Benefits *(cont'd.)*

Inpatient Benefits

Blue Shield Medicare (PPO) individual and group plans provide benefits for treatment in hospitals and skilled nursing facilities (SNFs) and extend the basic benefits provided by Medicare. Blue Shield Medicare (PPO) individual and group plans provide coverage according to Medicare guidelines.

In addition to hospital care, Blue Shield Medicare (PPO) individual and group members who meet Medicare guidelines for skilled nursing facility care have coverage for SNF benefits. Please refer to the Blue Shield Medicare (PPO) Summary of Benefits for the number of days covered for care provided by a skilled nursing facility.

Outpatient Benefits

Blue Shield Medicare (PPO) individual and group plans cover all outpatient medical services according to Medicare guidelines. Outpatient medical services are provided and paid for the diagnosis or treatment of illness and injury when they are considered to be reasonable and medically necessary. Please refer to the *Blue Shield Medicare (PPO) Summary of Benefits* (sent separately to IPA/medical groups) for a list of covered outpatient services.

Blue Shield Medicare (PPO) (Medicare Advantage) *(cont'd.)*

Blue Shield Medicare (PPO) Benefits *(cont'd.)*

Outpatient Prescription Drugs

Blue Shield Medicare (PPO) individual and group plans provide coverage for plan-approved generic and brand name prescription medications included in the Blue Shield Medicare (PPO) Drug Formulary. The formulary may vary by plan, by plan service area, or by employer group. The formulary for group plan members includes some drugs that are "excluded" drugs per CMS. The employer groups may choose to cover some of these excluded drugs as part of their additional supplemental coverage. Some formulary medications may require prior authorization or step therapy. The Blue Shield Medicare (PPO) utilization management criteria can be found within the plan drug search tools located at blueshieldca.com/medformulary2022. Prescriptions from non-plan providers are covered only if issued in conjunction with covered emergency services and filled through a network pharmacy.

The formulary contains medications approved by the Food & Drug Administration (FDA) which are subject to a rigorous clinical review by clinical pharmacists and physicians to evaluate comparative safety, comparative efficacy, likelihood of clinical impact, cost-effectiveness when safety and efficacy are similar. The Blue Shield Pharmacy & Therapeutics (P&T) Committee determines formulary decisions and medication coverage policies consistent with the currently accepted medical evidence and standards. The Blue Shield P&T Committee has oversight responsibility for pharmaceutical/utilization management programs, drug utilization review programs, and other drug-related matters impacting patient care. The voting members of the P&T Committee include actively participating network physicians and clinical pharmacists who are not employees of Blue Shield. The P&T Committee determines formulary status and/or medication coverage policies for drugs covered in the prescription benefit on at least a quarterly basis.

In general, outpatient prescription drugs are covered under Blue Shield Medicare (PPO) when they are:

- Included in the Blue Shield Medicare (PPO) Drug Formulary. (Blue Shield may periodically add, remove and/or make changes to coverage limitations on certain drugs, or alter the member price of a drug. If Blue Shield implements a formulary change that limits member ability to fill a prescription, Blue Shield will notify affected enrollees in advance of the change.)
- Prescribed by a provider (a doctor, dentist, or other prescriber) who either accepts Medicare or has filed documentation with CMS showing that he or she is qualified to write prescriptions.

Blue Shield Medicare (PPO) (Medicare Advantage) *(cont'd.)*

Blue Shield Medicare (PPO) Benefits *(cont'd.)*

Outpatient Prescription Drugs *(cont'd.)*

- Filled at a Blue Shield Medicare (PPO) network pharmacy.
- Used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by the following CMS-approved references: the *American Hospital Formulary Service Drug Information*; the *DRUGDEX Information System*; the *USPDI*; and the *National Comprehensive Cancer Network and Clinical Pharmacology*, or their successors.

Network Retail Pharmacy – A pharmacy where members can get their prescription drug benefits. They are termed "network pharmacies" because they contract with our plan. In most cases, member prescriptions are covered only if they are filled at one of our network pharmacies.

Standard Cost-Sharing – Standard cost-sharing is cost-sharing other than preferred cost-sharing offered at a network pharmacy.

Preferred Cost-Sharing – Preferred cost-sharing means lower cost-sharing for certain covered Part D drugs at certain network pharmacies.

Out-of-Network Pharmacy – A pharmacy that does not have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs that members get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Non-Formulary Outpatient Prescription Drugs

If a drug is not listed in the Blue Shield Medicare (PPO) individual or group drug formulary, the prescriber or member may contact Blue Shield Medicare (PPO) Member Services to confirm the drug's coverage status.

If Member Services confirms that the drug is not part of the Blue Shield Medicare (PPO) individual or group drug formulary and not covered, the member has two options:

- The member can ask the prescriber to prescribe a different drug, one that is part of the Blue Shield Medicare (PPO) individual or group drug formulary.
- The member can request that Blue Shield make a Formulary Exception (a type of Coverage Determination) to cover the specific drug.

If a member recently joined Blue Shield and is taking a drug not listed in the Blue Shield Medicare (PPO) Drug Formulary at the time he/she joined, the member may be eligible to obtain a temporary supply. For more information, please refer to the next section, which reviews the rules that govern dispensing temporary supplies of a non-formulary drug.

Blue Shield Medicare (PPO) (Medicare Advantage) *(cont'd.)*

Blue Shield Medicare (PPO) Benefits *(cont'd.)*

Non-Formulary Outpatient Prescription Drugs *(cont'd.)*

Transition Policy

New Blue Shield members may be taking drugs not listed in the Blue Shield Medicare (PPO) individual or group drug formulary, or the drug(s) may be subject to certain restrictions, such as prior authorization or step therapy. Members are encouraged to talk to their doctors to decide if they should switch to an appropriate drug in the plan formulary or request a Formulary Exception (a type of Coverage Determination) in order to obtain coverage for the drug. While these new members may discuss the appropriate course of action with their doctors, Blue Shield may also cover the non-formulary drug or drug with a coverage restriction in certain cases during the first 90 days of new membership.

For each of the drugs not listed in the formulary or that have coverage restrictions or limits, Blue Shield will cover a temporary 30-day supply (unless the prescription is written for fewer days) when the new member goes to a Network Pharmacy (and the drug is otherwise a "Part D drug"). After the first 30-day supply, Blue Shield will not pay for these drugs, even if the new member has been enrolled for less than 90 days.

If a member is a resident of a long-term-care facility (LTC) such as a nursing home, Blue Shield will cover supplies of Part D drugs in increments of 14 days or less for a temporary 31-day transition supply (unless the prescription is written for fewer days) during the first 90 days a new member is enrolled in our Plan beginning on the member's effective date of coverage. A transition supply notice will be sent to the member within 3 business days of the first incremental transition fill. If the LTC resident has been enrolled in our Plan for more than 90 days and needs a non-formulary drug or a drug that is subject to other restrictions, such as step therapy or dosage limits, Blue Shield will cover a temporary 31-day emergency supply of that drug (unless the prescription is for fewer days) while the new member pursues a formulary exception. For members being admitted to or discharged from a LTC facility, early refill edits are not used to limit appropriate and necessary access to the formulary, and such enrollees are allowed to access a refill upon admission or discharge.

Blue Shield Medicare (PPO) (Medicare Advantage) *(cont'd.)*

Blue Shield Medicare (PPO) Benefits *(cont'd.)*

Non-Formulary Outpatient Prescription Drugs *(cont'd.)*

Transition Policy *(cont'd.)*

To request a Formulary Exception (a type of Coverage Determination), Prescribers should submit persuasive evidence in the form of studies, records, or documents to support the existence of the situations listed above via a prior authorization request.

Providers can submit a prior authorization request electronically by utilizing one of our contracted electronic prior authorization (ePA) vendors, Surescripts or Cover My Meds. Providers also have the option to request a prior authorization or exception request by faxing a Medicare Coverage Determination Request Form (available at blueshieldca.com/provider) to (888) 697-8122 or via phone to (800) 535-9481 Monday through Friday, 8:00 a.m. until 6:00 p.m. PST, excluding holidays.

Providers have the alternate option to use AuthAccel to complete, submit, attach documentation, track status, and receive determinations for pharmacy prior authorizations. Registered users may access the tool, in the *Authorizations* section, after logging into Provider Connection at blueshieldca.com/provider. When providers submit requests via AuthAccel, it is not necessary for them to complete a separate Medicare Coverage Determination Request Form, as the required information is built into the tool.

Once all required supporting information is received, a coverage decision based upon medical necessity is provided within 24 hours for an expedited review and 72 hours for standard requests.

Blue Shield Medicare (PPO) (Medicare Advantage) *(cont'd.)*

Blue Shield Medicare (PPO) Benefits *(cont'd.)*

Vision Services

Blue Shield Medicare (PPO) individual and group plans cover vision services that meet Medicare guidelines.

In addition to Medicare-covered services, all Blue Shield Medicare (PPO) individual and some group plans cover routine (non-Medicare covered) eye examinations/screenings. For individual and group plans, services are provided through VSP Vision Care. Refer to the Blue Shield Medicare (PPO) Summary of Benefits for benefit guidelines.

Hearing Services

Blue Shield Medicare (PPO) individual and group plans cover hearing exams in accordance to Medicare guidelines. Please refer to the member's *Blue Shield Medicare (PPO) Summary of Benefits* for additional information.

Optional Buy-Up Services (Group Members Only)

Blue Shield Medicare (PPO) also offers optional buy-up benefits for hearing aids, vision, podiatry, chiropractic, and acupuncture that offer routine coverage beyond what is covered by Medicare. In addition, Silver Sneakers Fitness is available. These benefits are not part of the standard plan offering and may be available at an additional cost when selected by the employer group/union. If purchased, they must be made available to all Blue Shield Medicare (PPO) GMAPD members within that employer group/union. (There are also optional buy-up dental plans being offered to Blue Shield Medicare (PPO) individual plan members.)

Blue Shield Medicare (PPO) (Medicare Advantage) *(cont'd.)*

Exclusions to Blue Shield Medicare (PPO) Benefits

General Benefit Exclusions

Blue Shield files benefits with CMS on an annual basis. Coverage for the following benefits, services, and conditions are **excluded** from coverage under the Blue Shield Medicare (PPO) plan, effective January 1, 2020:

- Services considered not reasonable and necessary, according to the standards of Original Medicare, unless these services are listed by our plan as covered services.
- Experimental medical and surgical procedures, equipment, and medications, unless covered by Original Medicare or under a Medicare-approved clinical research study or by our plan. Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.
- Private room in a hospital, except when it is considered medically necessary.
- Private duty nurses.
- Personal items in a member's hospital room or a skilled nursing facility room, such as a telephone or a television.
- Full-time nursing care in the member's home.
- Custodial care unless it is provided with covered skilled nursing care and/or skilled rehabilitation services. Custodial care, or non-skilled care, is care that helps members with activities of daily living, such as bathing or dressing.
- Homemaker services include basic household assistance, including light housekeeping or light meal preparation.
- Fees charged by the member's immediate relatives or members of their household.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, and mental performance), except when medically necessary.
- Cosmetic surgery or procedures, unless because of an accidental injury or to improve a malformed part of the body. However, all stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
- Routine chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines, unless specifically indicated as covered by the Blue Shield Medicare (PPO) plan in which the member is enrolled.

Blue Shield Medicare (PPO) (Medicare Advantage) *(cont'd.)*

Exclusions to Blue Shield Medicare (PPO) Benefits *(cont'd.)*

General Benefit Exclusions *(cont'd.)*

- Unless the member has enrolled in the optional supplemental dental PPO benefit, routine dental care, such as cleanings, fillings, or dentures, unless specifically indicated as covered by the Blue Shield Medicare (PPO) plan in which the member is enrolled. Non-routine dental care received at a hospital may be covered.
- Routine foot care, except for the limited coverage provided according to Medicare guidelines or as specifically indicated as covered by the Blue Shield Medicare (PPO) plan in which the member is enrolled.
- Orthopedic shoes unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
- Routine hearing exams, hearing aids, or exams to fit hearing aids, unless specifically indicated as covered by the Blue Shield Medicare (PPO) plan in which the member is enrolled.
- Eyeglasses, routine eye examinations, radial keratotomy, LASIK surgery, vision therapy, and low vision aids unless specifically indicated as covered by the Blue Shield Medicare (PPO) plan in which the member is enrolled.
- Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies.
- Routine Acupuncture, except for chronic low back pain, unless specifically indicated as covered by the Blue Shield Medicare (PPO) plan in which the member is enrolled.
- Naturopath services (uses natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities. However, when emergency services are received at a VA hospital and the VA cost-sharing is more than the cost-sharing under our plan, Blue Shield will reimburse veterans for the difference. Members are still responsible for our cost-sharing amounts.
- Immunizations for foreign travel purposes.

The plan will not cover the excluded services listed above. Even if members receive the services at an emergency facility, the excluded services are still not covered.

Blue Shield Medicare (PPO) (Medicare Advantage) *(cont'd.)*

Exclusions to Blue Shield Medicare (PPO) Benefits *(cont'd.)*

Prescription Drug Benefit Exclusions

Blue Shield files benefits with CMS on an annual basis. The following exclusions apply to the Blue Shield Medicare (PPO) prescription drug benefits:

- Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B. This includes any injectable or infusible drug that is defined by a Medicare contractor as usually not self-administrable (e.g., chemotherapy and supportive/adjunctive injectable drugs), any drug that is administered to the member or dispensed within the four walls of a provider's office or facility, or any drug BSC has determined, based on medical literature, there exist safety concerns such that it would go against accepted medical practice for a particular injectable or infusible drug to be dispensed directly to a patient.
- Drugs purchased outside the United States and its territories are not covered.
- Off-label use of prescription drugs is usually not covered. "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration. Generally, coverage for "off-label use" is allowed only when the use is supported by the following CMS-approved references: the *American Hospital Formulary Service Drug Information,* the *DRUGDEX Information System*, for cancer the *National Comprehensive Cancer Network and Clinical Pharmacology,* and *Lexi-Drugs* or their successors. If the use is not supported by one of these reference sources, then our plan cannot cover its "off-label use."
- By law, the following categories of drugs are not covered by Medicare drug plans:
  - Non-prescription drugs (also called over-the-counter drugs)
  - Drugs related to assisted reproductive technology (ART)
  - Drugs when used for the relief of cough or cold symptoms
  - Drugs when used for cosmetic purposes or to promote hair growth
  - Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
  - Drugs when used for the treatment of sexual or erectile dysfunction (ED)
  - Drugs that are prescribed for medically accepted indications other than sexual or erectile dysfunction (such as pulmonary hypertension) are eligible for Part D coverage
  - Drugs when used for treatment of anorexia, weight loss, or weight gain
  - Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

National Medicare Coverage Determinations

A National Coverage Determination (NCD) is a national policy determination made by CMS regarding the coverage status of a particular service under Medicare. A NCD does not include a determination of what code, if any, is assigned to a service or a determination about the payment amount for the service.

National Medicare Coverage Determinations that arise between contract years allow Medicare Advantage Organizations and contracted providers to bill Medicare on a fee-for-service basis for newly covered items that exceed the significant cost criterion.

When the significant cost criterion is not met:

- The MAO is required to provide coverage for the NCD or legislative change in benefits and assume risk for the costs of that service or benefit as of the effective date of the NCD or as of the date specified in the legislation/regulation.

When the significant cost criterion is met:

- The MAO is not required to assume risk for the costs of that service or benefit until the contract year for which payments are appropriately adjusted to take into account the significant cost of the service or benefit. However, a plan must pay for the following:
    - Diagnostic services related to the NCD item, service, or legislative change in benefits and most follow-up services related to the NCD item, service, or legislative change (42 CFR § 422.109(c)(2)(i),(ii));
    - NCD items, services, or legislative change in benefits that are already included in the plan's benefit package either as Original Medicare benefits or supplemental benefits.

Billing to Medicare must include a notice that the item being billed involves a new coverage issue and that the person or organization submitting the bill is requesting fee-for-service reimbursement.

For select medications, Blue Shield Medicare PPO Medication Policies and Step Therapy requirements may also apply. The Blue Shield Medicare (PPO) benefit for medication coverage under the benefit can be found on Provider Connection at blueshieldca.com/provider under *Authorizations*, *Clinical policies and guidelines*, and then *Medication Policy*.

For more information on NCDs, go to the Medicare Coverage Database on the CMS website at https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx

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

Network	How Care is Accessed	Financial Responsibility
HMO Network	Member's care is coordinated through the primary care physician who makes any necessary specialist referrals.	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.
PPO In-network	Member self-refers to a Blue Shield Preferred Provider.	Applicable PPO copayment and deductible applies.
Non-Network PPO (non-preferred or non-participating)	Member self-refers to a non-network provider.	Applicable PPO copayment and deductible applies. Member may be balance-billed.

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) (PPO)

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 Anthem Blue Cross' Preferred Hospitals. FEP members may select the FEP Blue Focus, 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. FEP Blue Focus Members and Basic Option Member's must seek care from in-network providers to be covered for any services. 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

Federal Employee Program (FEP) (PPO) *(cont'd.)*

About the BlueCross and BlueShield Service Benefit Plan *(cont'd.)*

Under both the FEP Blue Focus and the Basic Option plans, members must use Preferred providers in order to receive benefits, except under the following special circumstances. In addition, certain types of care must be approved in advance.

- 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, other than those described above. We encourage the member to contact Blue Shield of California for more information in these types of situations before they receive services from a non-preferred provider.
- Care received outside the United States, Puerto Rico, and the U.S. Virgin Islands

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 precertification for all inpatient admissions to preferred hospitals. Precertification 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 precertification is not obtained. The member is ultimately responsible for ensuring that precertification has been completed. If the precertification 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).

Precertification is not needed for a maternity admission for a routine delivery. However, if the mother's medical condition requires her to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, the physician or the hospital must contact Blue Shield for precertification of additional days. Further, if the baby stays after the mother is discharged, then the physician or the hospital must contact Blue Shield for precertification of additional days for the baby.

> *Note:* When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in his or her own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.

Federal Employee Program (FEP) *(cont'd.)*

Mental Health and Substance Use Disorder Services for FEP

It is important to follow these policies to help ensure your patient's needs for mental health and substance use disorder 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 Mental Health and Substance Use Disorder 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, telehealth, or home visits for FEP PPO members. For questions regarding coverage, please call FEP Customer Service at (800) 824-8839. For questions regarding prior authorization call FEP Prior Authorization department at (800) 633-4581.

Federal Employee Program (FEP) *(cont'd.)*

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.

Prior Approval is required for:	Additional Information
Outpatient sleep studies performed outside the home	Prior approval is required for sleep studies performed in any other location that is not the member's home.
Applied behavior analysis (ABA)	Prior approval is required for ABA and all related services, including assessments, evaluations, and treatments.
Gender affirmation surgery	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.
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:* Necessary medical evidence for BRCA related genetic testing includes the results of genetic counseling. Genetic counseling and evaluation services are required before *preventive* BRCA testing is performed.

Federal Employee Program (FEP) *(cont'd.)*

Required Prior Authorization *(cont'd.)*

Prior Approval is required for:	Additional Information
Surgical services	Morbid Obesity- See the Blue Cross Blue Shield Service Benefit Plan Brochure for requirements. Surgical correction of congenital anomalies (see definition in the Service Benefit Plan Booklet); and oral maxillofacial surgery needed to correct accidental injuries to jaws, cheeks, lips, tongue, roof, and floor of mouth (see definition in the Service Benefit Plan Brochure). Orthognathic surgery procedures, bone grafts, osteotomies, and surgical management of the temporomandibular joint (TMJ). Breast reduction or augmentation not related to treatment of cancer. Reconstructive surgery for conditions other than breast cancer. Orthopedic procedures: hip, knee, ankle, spine, shoulder, and all orthopedic procedures using computer-assisted musculoskeletal surgical navigation. Rhinoplasty, Septoplasty and Varicose vein treatment. 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.

Federal Employee Program (FEP) *(cont'd.)*

Required Prior Authorization *(cont'd.)*

Prior Approval is required for:	Additional Information
Transplants – Prior approval is required for both the procedure and the facility	Prior Approval is required for all transplants, except cornea and kidney. Covered Organ/tissue Transplants - See the list of covered transplant services in the Blue Cross Blue Shield 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. For Medicare's approved programs, go to https://qcor.cms.gov/main.jsp 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. *Note*: For the purposes of the blood or marrow stem cell clinical trial transplants covered under this Plan, a clinical trial is a research study whose protocol has been reviewed and approved by the Institutional Review Board (IRB) of the FACT-accredited facility, Blue Distinction Center for Transplants, or Cancer Research Facility where the procedure is to be performed. Clinical trials for certain blood or marrow stem cell transplants – See the list of conditions covered only in clinical trials in the Blue Cross Blue Shield Service Benefit Plan Brochure. All members (including those who have Medicare Part A or another group health insurance policy as their primary payor) must contact us at the customer service telephone number listed on the back of their ID card before obtaining services.
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 to request prior approval, or to obtain a list of drugs and supplies that require prior approval. *Note:* 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.

Federal Employee Program (FEP) *(cont'd.)*

Required Prior Authorization *(cont'd.)*

Prior Approval is required for:	Additional Information
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.
Specialty DME	Specialty hospital beds, deluxe wheelchairs, power wheelchairs and mobility devices including scooters and related supplies.
Gene Therapy and Cellular Immunotherapy	Including Car-T and T-cell receptor therapy.
Air Ambulance Transport (Non-Emergent)	Air ambulance transport related to immediate care of a medical emergency or accidental injury does not require prior approval.
Outpatient Intensity Modulated Radiation Therapy (IMRT)	Prior approval is required for all outpatient IMRT services except IMRT related to the treatment of head, neck, breast, prostate, or anal cancer. Brain cancer is not considered a form of head or neck cancer; therefore, prior approval is required for IMRT treatment of brain cancer.
Rehabilitation Services	Cardiac Rehab and Pulmonary Rehab.
Devices	Cochlear implants and external prosthetic devices, including microprocessor-controlled limb prosthesis and electronically and externally powered prosthesis.
Outpatient Residential Treatment Center Care	For any condition.
High tech Radiology	MRI, CT, and PET Scans. *Note*: High technology radiology related to immediate care of a medical emergency or accidental injury does not require 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 Care 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 Care Management Program include:

- Acute Catastrophic – Includes members with immediate needs relating to an acute episode of care for conditions such as stroke, septicemia, 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 Substance Use Disorder diagnosis. Participates in discharge planning for all inpatient mental health and substance use disorder 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 link to a Guided Imagery Toolkit is available to members prior to or following surgery 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:

Plan and Group Numbers	Medicare Unassigned Claims
Benefit Plan A, B, C, D, H, K, N	Patients pay balance of billed charges (limiting charge).*
Benefit Plan F, G, I, J	Blue Shield pays 100 % of the difference between Medicare's payment and billed charges.
Golden Coronet Senior	Blue Shield pays 80 % of the difference between Medicare's payment and billed charges. Patients pay balance of billed charges.*
Coronet Major Medicare	Patients pay balance of billed charges (limiting charge).*
Coronet Senior	Patients pay balance of billed charges (limiting charge).*
Preferred Senior	Patients pay balance of billed charges (limiting charge).*

*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 other 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 https://www.blueshieldca.com/bsca/bsc/wcm/connect/provider/provider_content_en/guidelines_resources/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. The Other Payor Summary List is located on Provider Connection at www.blueshieldca.com/bsca/bsc/wcm/connect/provider/provider_content_en/guidelines_resources/policies_standards/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 and Substance Use Disorder Services

The terms "mental health and substance use disorder services" and "behavioral health" are used interchangeably throughout this manual.

Blue Shield provides coverage for the diagnosis and medically necessary treatment of mental health and substance use disorders. This includes conditions that fall under any diagnostic categories of the World Health Organization's *International Statistical Classification of Diseases and Related Health Problems* or that are listed in the most current edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). Blue Shield's mental health service administrator (MHSA) for commercial HMO and PPO members is Human Affairs International of California (HAI-CA).

Members must utilize the Blue Shield MHSA provider network to access mental health and substance use disorder covered services. The MHSA participating provider must obtain prior authorization from the MHSA for services listed under the section Blue Shield MHSA Covered Services for Commercial Plan Members below.

Mental health and substance use disorder office visits **do not** require prior authorization.

Commercial HMO and PPO members should use the Member Self-Referral phone number (877) 263-9952 to contact Blue Shield's MHSA to access behavioral health care.

Mental Health and Substance Use Disorder Services *(cont'd.)*

Primary Care Physician Consultation Line

The Blue Shield MHSA offers a Primary Care Physician Consultation Line at (877) 263-9870 to facilitate Primary Care Physician discussion with a Board-Certified psychiatrist regarding mental health and substance use disorder 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 online PCP Behavioral Health Toolkit at any time by visiting blueshieldca.com/provider, selecting *Guidelines & resources*, *Patient care resources*, *Behavioral health resources,* then *PCP Behavioral Toolkit*. 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 *Provider Search Telebehavioral* on the left of the screen.

Mental Health and Substance Use Disorder Services *(cont'd.)*

Blue Shield MHSA Covered Services for Commercial Plan Members

The Blue Shield MHSA will utilize ASAM, LOCUS, CALOCUS, and ECSII for mental health and substance use disorder reviews for commercial members. Additional mental health and substance use disorder guidelines may be added as they become available from non-profit professional associations in accordance with California law.

Blue Shield's MHSA is responsible for prior authorization and paying claims for the following services:

- Non-emergency mental health or substance use disorder Hospital inpatient admissions, including acute and residential care
- Outpatient Mental Health and Substance Use Disorder Services listed below when provided by a MHSA contracted provider, as required by the applicable plans *Evidence of Coverage* or *Health Service Agreement.*
  - Behavioral Health Treatment (BHT) including Applied Behavior Analysis (ABA).
  - Electro-convulsive Therapy (ECT) and associated anesthesia.
  - Intensive Outpatient Program.
  - Partial Hospitalization Program.
  - Neuropsychological Testing should be considered for coverage through the patient's mental health benefit when:
    - After completion of a comprehensive Behavioral Health evaluation and neurological evaluation, if the Behavioral Health provider or neurologist determines the neuropsychological testing is required, the provider will request authorization and coordinate the request, Blue Shield MHSA will cover Neuropsychological testing when the purpose of testing is to clarify whether there is a psychiatric diagnosis (even when medical conditions are present) for the purposes of facilitating treatment.
  - Transcranial Magnetic Stimulation.
  - Non-emergency inter-facility transports.

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

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

Mental Health and Substance Use Disorder Services *(cont'd.)*

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

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

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

Section 2: Service Accessibility Standards for Behavioral Health
Section 5: Federal Employee Program (FEP) (PPO); Mental Health and Substance Use Disorder Services for FEP

Ancillary Benefits

The following benefits are listed in the members' *Evidence of Coverage* (EOC) and will include the number of allowed visits and member copay responsibility. Providers are required to look up members benefits and eligibility on Provider Connection at blueshieldca.com/provider under *Eligibility and benefits.* Review the benefits for acupuncture and chiropractic to determine if the members plan includes these benefits as they may or may not be included and vary by plan.

Acupuncture Services

For Blue Shield fully-insured plans, benefits are provided for medically necessary acupuncture services, for a maximum number of visits per calendar year, when received from an American Specialty Health Group, Inc. (ASH Group) participating provider. Covered services must be determined as Medically Necessary by American Specialty Health Plans, Inc. (ASH Plans). This benefit includes an initial examination, subsequent office visits, acupuncture services, and adjunctive therapy specifically for the treatment of neuromusculoskeletal disorders, nausea, and pain up to the benefit maximum.

Questions concerning these benefits may be directed to:

ASH Plan Member Services (800) 678-9133

ASH Plan Provider Services (800) 972-4226

For Self-Funded, ASO, Shared Advantage, FEP PPO, and BlueCard members, all medically necessary acupuncture services that are included in these plans are provided by Blue Shield's direct network of acupuncturists.

Ancillary Benefits *(cont'd.)*

Chiropractic Services

For Blue Shield fully-insured plans, benefits are provided for medically necessary chiropractic services, including spinal manipulation or adjustment, when received from an American Specialty Health Group, Inc. (ASH Group) participating provider. Covered services must be determined as Medically Necessary by American Specialty Health Plans, Inc. (ASH Plans). This benefit includes an initial examination and subsequent office visits, adjustments, and adjunctive therapy up to the benefit maximum. Benefits are also provided for x-rays.

Members are referred to the primary care physician for evaluation of conditions not related to a neuromusculo-skeletal disorder and of evaluation for non-covered services, such as CT Scans or MRIs.

Chiropractic appliances are covered up to a maximum of $50 in a calendar year as authorized by ASH Plans.

Questions concerning these benefits may be directed to:

ASH Plan Member Services (800) 678-9133

ASH Plan Provider Services (800) 972-4226

For Self-Funded, ASO, Shared Advantage, FEP PPO, and BlueCard members, all medically necessary chiropractic services that are included in these plans are provided by Blue Shield's direct network of chiropractors.

Additional Hearing Aid Benefits

For Core Accounts, this optional coverage includes hearing aid services subject to the conditions and limitations listed below. This rider provides an allowance towards the purchase of hearing aids and ancillary equipment.

For benefit coverage, review the member's Hearing Aid Rider language to obtain allowance, frequency, and limitations of the hearing aid benefit.

The hearing aid allowance includes:

- A hearing aid instrument, monaural, or binaural, including ear mold(s)
- Visit for fitting, counseling, device checks and adjustments
- Electroacoustic evaluations for hearing aids
- The initial battery and cords

Ancillary Benefits *(cont'd.)*

Additional Hearing Aid Benefits *(cont'd.)*

The following services and supplies are not covered:

- Purchase of batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase
- Spare hearing aids
- Assisted listening devices or amplification devices
- Charges for a hearing aid which exceed specifications prescribed for correction of a hearing loss
- Replacement parts for hearing aids, repair of hearing aid after the covered warranty period and replacement of a hearing aid more than the benefit allowance period
- Surgically implanted hearing devices

Additional Infertility Benefits

Covered services for Infertility Benefit include all professional, hospital, ambulatory surgery center, ancillary services, injectable drugs when authorized by the primary care physician, to a member for the inducement of fertilization.

Please refer to the member's Infertility Benefit Rider for coverage limitations, exclusions, lifetime maximums and copayments, coinsurance, and deductibles. Benefits are only provided for services received from a Participating Provider.

Infertility is defined as:

The member must be actively trying to conceive and has either:

1) A demonstrated condition recognized by a licensed physician and surgeon as a cause for infertility; or

2) The inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year of regular sexual relations without contraception.

Note: Services to diagnosis and treat the cause of infertility are covered by all group HMO plans under basic medical benefits.

The IPA/medical group provider network is to be used for all infertility services. All covered services under the infertility rider are the financial responsibility of and are authorized and reimbursed by Blue Shield.

Ancillary Benefits *(cont'd.)*

Dental

Section 1367.71 of the Health & Safety Code requires that health plans cover general anesthesia and associated facility charges for dental procedures performed in a hospital or surgery center when required due to clinical status or underlying medical condition, and:

- The patient is less than seven years of age, or
- The patient is developmentally disabled, regardless of age, or
- The patient's health is compromised and for whom general anesthesia is medically necessary, regardless of age.

Prior authorization is required by Blue Shield HMO and coverage for anesthesia and associated facility charges are subject to all other terms and conditions of the plan. Blue Shield HMO is not responsible for the cost of dental procedures. Dental procedures for diagnostic services, endodontics, periodontics, preventive care, prosthetics, and restorative dentistry are covered in plans administered by Dental Benefit Providers of California (DBP) and are available for purchase separately from medical plans.

Vision

This benefit is administered through EyeMed. It covers services for refractions, lenses, and frames. Any questions concerning these benefits may be directed to:

EyeMed (877) 601-9083

Blue Shield Benefit Programs

Care Management

Blue Shield's comprehensive, integrated care management programs, including Shield Support, Shield Advocate, Shield Concierge, and Connect, include member-focused clinical interventions to optimize health and quality of life. These programs offer 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.

Blue Shield's experienced care management 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.

Blue Shield's 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. The care team prepares members in advance for hospital stays, including guided imagery recordings to assist members in preparing for surgery or dealing with other health issues. These programs are supported by medical directors who provide clinical direction and oversight to the care team.

Blue Shield's care management programs are 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.

Care Management *(cont'd.)*

Member identification for Blue Shield's care management programs 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.

Members may also be identified from an acute event or hospital admission or discharge. Care management encompasses a broad spectrum of interventions that provide support for short-term care coordination as well as ongoing complex case management including but not limited to 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 care management programs:

- Telephonic coaching from nurses, behavioral health clinicians, social workers, and pharmacists
- Biometric home monitoring (for some members with diabetes, coronary artery disease, COPD, and heart failure)
- Cognitive behavioral therapy modules
- Online tools and educational materials

In addition to the care management programs described above, the following maternity support is available.

Care Management *(cont'd.)*

Maternity Management

Blue Shield has teamed up with Maven to offer Maven Maternity to our members. Maven Maternity is a 24/7 digital and virtual program designed to support Blue Shield members during and after pregnancy. Maven is also available to eligible Blue Shield medical plan members and their partners who have experienced a pregnancy loss. Blue Shield members can use Maven to book coaching and educational video appointments with providers across more than 30 specialties, including OB-GYNs, mental health specialists, doulas, lactation consultants, and more. Providers can encourage members to enroll in the Maven Maternity Program by visiting blueshieldca.com/maternity.

Screening, treatment, and referral to services for maternal mental health-related conditions is strongly encouraged. If a member screens positive for a mental health condition, such as anxiety or depression, Blue Shield physicians can refer directly to a behavioral health provider. Physician referrals are an important component of Blue Shield's Care Management Programs and may allow for identification of a member in need more quickly. Blue Shield providers may connect a member to appropriate maternal mental health resources through accessing multiple pathways based on the member's needs. These include connecting directly to Maven, through Blue Shield Care Management, or behavioral health providers through the Mental Health Service Administrator, Magellan network.

Providers can refer to Blue Shield Care Management Programs 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. Providers can refer members to Magellan by calling Customer Service at (877) 263-9952 or request a clinical referral form at BSCClinicalLiaison@MagellanHealth.com. Each referral will be evaluated for eligibility and appropriateness.

Care Management *(cont'd.)*

Additional Care Management Program Descriptions

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.

Care Management *(cont'd.)*

Additional Care Management Program Descriptions *(cont'd.)*

- **Connect.** Connect offers an integrated, holistic, and personalized healthcare experience based on each member's needs, including a broad spectrum of robust, member-focused interventions driven by a smart-data platform with predictive analytics that leverage our best-in-class member care teams and digital wellness tools. The Connect care team is composed of specialists across claims and benefits, clinicians and care managers, pharmacists and technicians, behavioral health navigators, and social workers to address any questions that could be asked during the first call. In those rare instances in which additional information is needed and a call cannot be resolved, the Connect care team takes complete ownership for any remaining tasks and offers to call the member back once resolved. The Connect care team proactively engages members, either digitally or over the phone, when early interventions or extra communications might lead to better health outcomes. Members are guided to available programs and resources to address their health issues, prevent emergency-room visits, and avoid higher costs associated with inpatient admissions in the future.

- **Home-Based Complex Care.** Chronically ill members meeting certain criteria are offered 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 these chronically ill members with complex needs. This does not replace members' primary care providers but rather supports the work of these members' existing providers. The program clinicians communicate and collaborate with the patients' PCPs and specialists to reinforce the PCP's in-office care plan. Blue Shield identifies eligible members for this program based on their health status and needs.

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.

Home-Based Palliative Care Program *(cont'd.)*

Eligibility/Referral

The home-based palliative care program is available to all Blue Shield members except for those covered under a Federal Employee Plan (FEP) PPO, a Blue Shield Medicare supplemental insurance plan (Medigap), or those currently enrolled in hospice or who have an illness that is primarily a mental health 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 or online at blueshieldca.com/provider under *Forms*) 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:

Diabetes Prevention Program (DPP)

The Diabetes Prevention Program helps members who are at risk of type 2 diabetes lose weight and adopt healthy habits. During the six months program, 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 embedded in the Wellvolution platform can be accessed by enrolling in Wellvolution at wellvolution.com.

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 will 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 coach on money matters or an attorney on a variety of legal services. Members may be eligible to receive a 60-minute legal consult and two 30-minute financial consults at no cost to them.

- **Personal challenges including relationship problems or coping with grief** – Members receive 3 telephonic or face to face sessions with a licensed therapist in any six-month period 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, adult, and elder care, childcare, meal programs, relocation services, 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.

Wellness and Prevention Programs *(cont'd.)*

NurseHelp 24/7SM

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 at 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 Preventive health guidelines | Blue Shield of CA Provider (blueshieldca.com).

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.

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:

- **Fitness Your Way by Tivity** –With 4 different gym packages to choose from, including a digital only package, members have access to thousands of well-known fitness locations near home, work, or when traveling nationwide all for a low one time initiation fee and a low monthly cost. Simply visit fitnessyourway.tivityhealth.com/bsc to enroll.
- **Alternative Care Discounts** – 25% savings on acupuncture, chiropractic services, and therapeutic massage services from practitioners participating with the ChooseHealthy® program.
- **Discount Vision Program** – Discounts on vision exams, frames and lenses, contacts lenses, and more.
- **LASIK surgery** – Discounts on LASIK surgery through QualSight LASIK, and LASIK and PRK surgery through NVISION, Inc.

Wellness and Prevention Programs *(cont'd.)*

Wellvolution

Wellvolution focuses on things that make our members happier and healthier. The platform offers digital and in-person whole health programs designed to give our members a way to go beyond just doctors and prescriptions and live their best life. There are over 10 programs to choose from, ranging from general well-being, to supporting stress, sleep, and other mental health concerns, to helping members prevent or treat and reverse the course of serious chronic conditions. With the right tools, coaching, nutrition counseling and health professional support, members can succeed with small changes today to make a big difference for a healthier tomorrow. Once the member receives their Blue Shield member ID card, they can go to wellvolution.com to set up their profile, preferences and pick programs. Wellvolution customizes the path to better health, matching the member with programs and popular apps that are personalized and have proven results, at no extra cost.

The following programs are offered through Wellvolution:

- **Well-Being Programs –** A hand-selected set of proven general well-being programs, designed to help generally healthy members achieve their health goals of sleeping better, lowering stress, exercising more, eating better, or quitting smoking.
- **Mental Health Programs** – To support our members in achieving optimal whole person health, our mental health programs are perfect for members that are seeking opportunities to incorporate everyday mindfulness into their daily lives to reduce stress, increase resilience, and get a better night's rest as well as for members seeking support for low- to moderate- anxiety or depression. Programs include guided meditations, sleepcasts, mindfulness exercises, 24/7 Behavioral Health coaching, personalized care plan, and more.
- **Weight Loss Programs –** Programs specifically designed to help you make changes that fit your lifestyle and promote a healthy weight. You can lose weight and keep it off with coaching support and a personalized step by step plan on how to decrease cravings, hunger, and weight without dieting. Most members see an average loss of 3-4 lbs. per week and improvement in their quality of life across the board.

Wellness and Prevention Programs *(cont'd.)*

Wellvolution *(cont'd.)*

- **Disease Prevention Programs –** Targeting reduction of risk for type 2 diabetes and heart disease, prevention programs provide you with a health coach and an individualized plan that meet your unique needs and address several areas of your life, including physical activity, nutrition, sleep, and stress management. Most members see a reduction in medications they take, as well as normalization of blood sugar and blood pressure.
- **Chronic Condition Reversal Programs** – Turn back the clock and reverse the course of chronic conditions like hyperlipidemia, hypertension, type 2 diabetes and more with the support from physician, health coaches and a supportive patient community. Our high touch reversal programs, often incorporating in-person or digital coaching options, are focused on normalization of A1C levels, weight, and blood pressure, as well as elimination of medication dependence in a matter of weeks.

All Wellvolution programs are 100% covered by Blue Shield of California.