

Section 1: Introduction

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Section 1: Introduction

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Purpose of the Independent Physician and Provider Manual

The *Independent Physician and Provider Manual* describes the Blue Shield of California (Blue Shield) administrative guidelines, policies, and procedures for providers who are directly contracted with Blue Shield. The manual applies to providers of health care services for Blue Shield members covered under various Blue Shield health plans, including, but not limited to:

- Blue Shield PPO
- Access+ HMO® (Commercial HMO)
- Blue Shield Medicare Advantage Plans - Individual and Group

The information in this manual applies to the following types of providers who have signed a Blue Shield provider agreement:

- Physicians
- Acupuncturists
- Audiologists
- Chiropractors
- Hearing Aid Dispensers
- Hemophilia Infusion Providers
- Home Health Providers
- Home Infusion Providers
- Home Medical Equipment Providers
- Hospice Providers
- Laboratories
- Licensed Clinical Psychologists (LCPs)
- Licensed Clinical Social Workers (LCSWs)
- Licensed Professional Clinical Counselors (LPCCs)
- Marriage Family Therapists (MFTs)
- Occupational Therapists
- Opticians
- Optometrists
- Orthotics/Prosthetics Dispensers
- Other providers, as required
- Physical Therapists
- Podiatrists
- Speech and Language Pathologists

Note: The HMO information in this manual does not apply to Blue Shield providers when they provide healthcare services for HMO/POS members through their affiliation with a Blue Shield-contracted IPA/medical group. These providers should contact their affiliated IPA/medical group for information regarding its internal policies and procedures.

While this manual covers many areas regarding delivery and coordination of health care for Blue Shield members, it may not cover your specific issue or question. In those instances, please contact Provider Information & Enrollment at (800) 258-3091 for additional information.

Manual Orders and Updates

Go to Provider Connection at blueshieldca.com/provider to view and download a copy of this manual. The manuals are located under the *Provider manuals* section under the *Guidelines & resources* tab.

To order a copy of the manual on CD, email providermanuals@blueshieldca.com or contact Provider Information & Enrollment (800) 258-3091.

This manual is updated at least annually, in January.

Section 1: Introduction

Enrollment and Eligibility

Member Eligibility Verification

For routine eligibility verification, the provider may:

- Log onto Provider Connection at blueshieldca.com/provider for current and historical eligibility and benefit information that is updated daily.
- Use the Provider Customer Service toll-free number listed on the member's ID card to hear eligibility and request fax confirmation.

If eligibility cannot be verified, the provider should obtain written verification that the member agrees to accept financial responsibility if not eligible for Blue Shield coverage.

The provider may use his/her own office form or Blue Shield's Member Acknowledgment of Financial Responsibility Form for this purpose. A copy of this form can be found on Provider Connection at blueshieldca.com/provider under *Guidelines & resources, Forms, then Patient care forms*.

Monthly Eligibility Reports (Capitated Providers)

As a cost-effective measure, Blue Shield provides the Combined Eligibility/Capitation Report and the Eligibility Adds and Termination Report only in electronic format. Receiving eligibility information electronically enables capitated providers to use and sort the information in many ways to meet their specific reporting needs.

Blue Shield distributes these eligibility reports via Blue Shield secure email or SFTP to all capitated providers no later than the tenth of each calendar month. For details on the file formats, refer to Appendix 1 in the back of this manual.

Both reports include the member's name and identification number, the member's primary care physician name and identification number, as well as the activity code for all member status changes. The files also include the member's group number and Product IDs. The Product IDs are codes that identify the member's standard office visit copayments. Product IDs and Physician Office Copayment Guides are forwarded each month along with the Combined Eligibility/Capitation Reports.

Enrollment and Eligibility *(cont'd.)*

Premium Payment Policy

The member is responsible for payment of premiums to Blue Shield. Blue Shield does not accept direct or indirect payments of premiums from any person or entity other than the member, his or her family members or a legal guardian, or an acceptable third party payor, which are:

- Ryan White HIV/AIDS programs under Title XXVI of the Public Health Services Act;
- Indian tribes, tribal organizations or urban Indian organizations;
- A lawful local, State, or Federal government program, including a grantee directed by a government program to make payments on its behalf; and
- Bona fide charitable organizations and organizations related to the member (*e.g.*, church or employer) when all of the following criteria are met: payment of premiums is guaranteed for the entire plan year; assistance is provided based on defined financial status criteria and health status is not considered; the organization is unaffiliated with a healthcare provider; and the organization has no financial interest in the payment of a health plan claim. (Financially interested institutions/organizations include institutions/organizations that receive the majority of their funding from entities with a financial interest in the payment of health insurance claims, or institutions/organizations that are subject to direct or indirect control of entities with a financial interest in the payment of health insurance claims.)

Upon discovery that premiums were paid directly or indirectly by a person or entity other than the member or an acceptable third party payor, Blue Shield has the right to reject the payment and inform the member that the payment was not accepted and that the premiums remain due. Payment of member premiums by a Blue Shield contracted provider represents a material breach of the provider's agreement. Please note that processing any payment does not waive Blue Shield's right to reject that payment and future payments under this policy.

Blue Shield Enrollment Responsibilities to Members on the Exchange

Under the Patient Protection and Affordable Care Act (PPACA) for Exchange-purchased individual insurance policies eligible for premium subsidies, when premiums/dues are not received from members, there will be a three-month (90-day) delinquency period. During this grace period, Blue Shield may not disenroll delinquent members, but may suspend claims payments unless and until member premiums are received in full. See Section 4: Special Billing Situations for Blue Shield's responsibilities regarding unpaid premiums for Exchange members.

Section 1: Introduction

Enrollment and Eligibility *(cont'd.)*

Provider Requests to Transfer or Disenroll Members (Commercial)

Blue Shield policies for involuntary transfer or disenrollment of members are based on Health & Safety Code Section 1365 and California Code of Regulations Section 1300.65. Blue Shield retains sole and final authority to review and act upon the requests from providers to transfer or terminate a member. Members are not transferred against their will nor terminated until Blue Shield carefully reviews the matter, determines that transfer or termination is appropriate, and confirms that Blue Shield's internal procedures as outlined below have been followed. All transfer requests are carefully reviewed and care is taken to preserve member rights against discrimination due to age, race, gender, or health status.

A Blue Shield provider may not end its relationship with a member because of his or her medical condition or the cost and type of benefits that are required for treatment. A member who alleges that an enrollment has been canceled or not renewed because of the member's health status or requirements for health care services may request a review by the Department of Managed Health Care (DMHC).

Reasons for Immediate Disenrollment

Blue Shield may terminate coverage of a member for cause, **IMMEDIATELY** after the member receives written notice for any of the following:

- Fraud or an intentional misrepresentation of any material fact during the enrollment process.
- Permitting a non-member to use a member identification card to obtain services and benefits.
- Obtaining or attempting to obtain services or benefits under the contract using false, materially misleading, or fraudulent information, acts, or omissions.
- Exhibiting disruptive behavior or threatening the life or well-being of Blue Shield personnel, providers of services, or another Blue Shield member.

Reasons for Disenrollment that Require a 31-Day Notice

Blue Shield may terminate coverage of a member for cause after giving **31 DAYS** written notice for the following reasons:

- Inability to establish a satisfactory physician-patient relationship.
- Repeated and unreasonable demands for unnecessary medical services including medications when such demands are not in accordance with generally accepted professional standards.
- Failure to pay any copayment or supplemental charge.

Enrollment and Eligibility *(cont'd.)*

Provider Requests to Transfer or Disenroll Members (Commercial) *(cont'd.)*

Provider Procedures for Disenrollment

Before requesting to transfer or disenroll a member for cause, the provider counsels the member in writing about the problem. The letter to the member is sent by certified mail. If the problem continues, the provider may request disenrollment by sending all documentation, including the initial counseling letter, to the following address:

Blue Shield of California
Attention: Member Disenrollment
P.O. Box 272550
Chico, CA 95927-2550

Please provide Member Disenrollment with sufficient documentation so that Blue Shield will be able to make a decision based on the evidence.

1. Upon receipt of the transfer or disenrollment request and sufficient documentation, Blue Shield reviews the case and may:
 - Decide the evidence is not sufficient to disenroll the member.
 - Send a second counseling letter to the member.
 - Transfer the member to another Blue Shield provider (where the member has been provided appropriate 31 day written notice and there has been an irreconcilable breakdown in the patient /physician relationship).
 - Disenroll the member from the Blue Shield health plan with 31 days written notice.

Note: If the transfer request is received verbally by Blue Shield, the call is transferred to a Member/Customer Services Supervisor who forwards any pertinent information to Provider Information & Enrollment if necessary. The provider is advised to submit their request in writing to Blue Shield for review and follow-up as noted above.

2. Blue Shield sends the provider written notice of its decision.
 - If the provider does not provide adequate documentation to substantiate an involuntary transfer, Member/Customer Services and/or Provider Information & Enrollment contacts the provider and advises them that they must provide additional written documentation of the issues or events that lead to the transfer request.
 - If Blue Shield determines that a member transfer is warranted, the member is notified in writing (certified, return receipt) under the signature of the appropriate Blue Shield Member/Customer Services department. The transfer notification letter informs the member of the request made by the provider and the member can select another Blue Shield contracted provider. The letter clearly outlines the reasons why the request is being made and informs the member that if they do not select a new Blue Shield provider within 30 days of the date the letter was mailed, a new provider will be selected for them.

Section 1: Introduction

Enrollment and Eligibility *(cont'd.)*

Provider Requests to Transfer or Disenroll Members (Commercial) *(cont'd.)*

Provider Procedures for Disenrollment *(cont'd.)*

3. Once notice is given, members are transferred, effective the first of the following month unless an immediate transfer has been requested by the provider. If applicable, the letter informs the member that Blue Shield may pursue involuntary disenrollment if the events leading to the transfer reoccur. An explanation of the member's right to a hearing under Blue Shield's grievance procedures is also included in the letter.
 - When a member transfers to another Blue Shield provider, the previous provider provides patient records, reports and other documentation at no charge to Blue Shield, the new provider, or member.
 - The existing provider must continue to coordinate care through the date of transfer or disenrollment including timely processing of referrals.

Provider Requests to Transfer or Disenroll Members (Blue Shield Medicare Advantage Plan)

Blue Shield has established procedures, based on Centers for Medicare & Medicaid Services (CMS) requirements, for when network providers want to end their relationship with a Blue Shield Medicare Advantage plan member for cause, such as disruptive behavior or legal action by the member against the provider. This section defines acceptable reasons and procedures for processing provider requests to transfer Blue Shield Medicare Advantage plan members involuntarily while continuing to provide appropriate treatment with an existing healthcare provider.

Providers **may not** end a relationship with a member because of the member's medical condition or the cost and type of care that is required for treatment, or for the member's failure to follow treatment recommendations.

Blue Shield Medicare Advantage plan members **may not** be involuntarily transferred without Blue Shield Medicare Advantage plan approval. An involuntary transfer request would be considered only for the following situations:

- The member is disruptive, abusive, unruly, or uncooperative to the extent that the provider's ability to provide services is seriously impaired.

In this case, Blue Shield Medicare Advantage plan must review any request for an involuntary transfer request. The Blue Shield review, for most situations, looks for evidence that the individual continued to behave inappropriately after being counseled/warned about his or her behavior and that an opportunity was given to correct the behavior. The provider must have made several attempts to provide counseling to the member. A minimum of three (3) documented written warnings must be provided for consideration of an involuntary transfer request. Counseling done by plan providers is considered informal counseling and an initial warning letter related to the member's behavior must also be sent by Blue Shield. Blue Shield requires documentation/medical records from the physician group prior to sending the member an official warning letter from the plan. If the inappropriate behavior was due to a medical condition (such as any mental health issue or a physical disability), the provider must demonstrate that the underlying medical condition was controlled and was not the cause of the inappropriate behavior.

Enrollment and Eligibility *(cont'd.)*

Provider Requests to Transfer or Disenroll Members (Blue Shield Medicare Advantage Plan) *(cont'd.)*

- Legal action by a member against a physician or physician group can create a problematic situation in balancing the state and federal 30-day notice provisions related to involuntary disenrollments, along with the physician concerns about continuing to treat an individual who has filed a suit against a physician or physician group. Blue Shield Medicare Advantage plan's Customer Care staff can assist by contacting the member in such a circumstance. Since such litigation demonstrates a breakdown in the patient/physician relationship, Customer Care can verify if the member wishes to voluntarily transfer to a new Primary Care Physician (PCP) or physician group. While the circumstances will vary and may require individual review, in general, if a member does not wish to voluntarily transfer, Blue Shield would be required to provide the member with the requisite 30-day notice in order to comply with current legal requirements. In such circumstances, if the physician is not willing to see the patient during the 30-day transition period, the physician must make arrangements for the member to be seen by an alternate physician and notify Blue Shield and the member of the alternate arrangements in writing.

Procedure

Before requesting to involuntarily transfer a member for cause, the PCP must counsel the member verbally and in writing about the problem. Provider warning letters to the member must be sent by the provider via certified mail or a courier service to track that the warning letter was received (a copy of the letter must also be sent to the Blue Shield Medicare Advantage Customer Care Department). If the behavior or problem continues, the provider may request Blue Shield to take steps to counsel the member and initiate the protocols required for the plan to involuntarily transfer the member to another provider or physician group.

Providers are required to submit all documentation related to disruptive members to Blue Shield for review. This documentation includes:

- Documentation of the disruptive behavior, including a thorough explanation of the individual's behavior and how it has impacted the provider's ability to arrange for or provide services to the individual or other members;
- Written warning letters or counseling letters from the provider and/or the physician group showing serious efforts have been made to resolve the problem with the individual;
- Relevant police reports or documentation of intervention by the Police Department (if applicable);
- Documentation establishing that the member's behavior is not related to the use, or lack of use, of medical services;
- Proof that the member was provided with appropriate written notice of the consequences of continued disruptive behavior;
- Member information, including diagnosis, mental status, functional status, a description of his or her social support systems, and any other relevant information; and
- Proof of effort to provide reasonable accommodations for individuals with disabilities, if applicable, in accordance with the Americans with Disabilities Act.

The physician's or physician group's request for involuntary transfer for disruptive behavior must be complete. All documentation should be submitted to the Blue Shield Medicare Advantage plan Customer Care Department.

Section 1: Introduction

Enrollment and Eligibility *(cont'd.)*

Provider Requests to Transfer or Disenroll Members (Blue Shield Medicare Advantage Plan) *(cont'd.)*

Upon receipt of the transfer request and all required documentation, Blue Shield reviews the case and may:

- Decide the evidence is not sufficient to involuntarily transfer the member. The provider or physician group (where applicable) will be notified of the plan's determination.
- Send additional counseling letters to the member. CMS requires the plan to send an official warning letter to Blue Shield Medicare Advantage plan members describing the behavior that has been identified as disruptive and how it has impacted the plan's ability to manage the individual's care. (Note: If the disruptive behavior ceases after the member receives notice and later resumes, the involuntary disenrollment process must begin again.)
- Request Medical Care Solutions intervention to assist the member in managing their healthcare.
- Transfer the member to another network provider (where the member has been provided appropriate (30 day) written notice and there has been an irreconcilable breakdown in the patient/ physician relationship).

Note: If the transfer request is received verbally by Blue Shield from a PCP, the call is transferred to the appropriate Customer Care Team Leader who will request the written documentation and forward any pertinent information to Provider Relations and Medicare Compliance, as necessary. A verbal request will still require that the provider send Blue Shield all written documentation related to the member's behavior.

Blue Shield sends the provider a written notice of its decision. Please note that CMS considers counseling done by the PCP or physician group for Blue Shield Medicare Advantage plan members as informal notice and only recognizes counseling letters sent from the health plan as formal notification to the member.

Note: Providers must work with Blue Shield to provide sufficient documentation so that Blue Shield Medicare Advantage plan can send a formal warning notice to members.

- If the provider does not provide adequate documentation to substantiate an involuntary transfer request, Member Services and/or Provider Relations contacts the provider and advises them that they must provide additional written documentation of the issues or events that led to the transfer request.
- If Blue Shield determines that a member transfer is warranted, the member is notified in writing (certified, return receipt) under the signature of the appropriate Blue Shield Customer Care department. The transfer notification letter informs the member of the request made by the PCP and that the member can select another PCP in the same IPA/medical group or (if warranted) in another IPA/medical group. The letter clearly outlines the reasons why the request is being made and informs the member that if they do not select a new PCP within 30 days of the date the letter was mailed, a new PCP will be selected for them.

The member will be transferred once the written notice is given and is effective the first of the following month. If applicable, the letter informs the member that Blue Shield may pursue involuntary disenrollment through CMS if the events leading to the transfer reoccur. An explanation of the member's rights to a hearing under the Blue Shield Medicare Advantage plan grievance procedure is also included in the letter.

Enrollment and Eligibility *(cont'd.)*

Provider Requests to Transfer or Disenroll Members (Blue Shield Medicare Advantage Plan) *(cont'd.)*

- When a member transfers to a new IPA/medical group, the previous provider must supply patient records, reports and other documentation at no charge to Blue Shield, the new IPA/medical group, provider or member.
- The existing PCP must continue to coordinate care through the date of transfer.

Blue Shield follows regulatory guidelines and retains sole and final authority to review and act upon the requests from providers to transfer a member. Members are not transferred against their will until Blue Shield carefully reviews the matter, determines that transfer is appropriate, and confirms that Blue Shield's internal procedures have been followed. All transfer requests are carefully reviewed and care is taken to preserve member rights against discrimination due to age, race, gender, or health status.

In the unlikely event that one of the following extreme conditions arises, Blue Shield Medicare Advantage plan may have to discontinue benefits:

- Epidemic, riot, war, or major disaster.
- Complete or partial destruction of facilities.
- Loss or disability of a large number of our providers.

Under these extreme conditions, Blue Shield Medicare Advantage plan contracted hospitals and contracted providers will continue to make their best efforts to provide services. The member may go to the nearest medical facility for medically necessary services and will be reimbursed by Blue Shield for those charges.

Section 1: Introduction

Member Rights and Responsibilities

Blue Shield has established Member Rights and Responsibilities that all Blue Shield members receive in their *Evidence of Coverage* or *Certificate of Insurance*.

Statement of Member Rights

Blue Shield health plan members have the right to:

1. Receive considerate and courteous care, with respect for their right to personal privacy and dignity.
2. Receive information about all health services available to them, including a clear explanation of how to obtain health services.
3. Receive information about their rights and responsibilities.
4. Receive information about their health plan, the services we offer them, the physicians and other practitioners available to care for them.
5. If required, select a primary care physician and expect his/her team of health workers to provide or arrange for all in network care that they receive.
6. Have reasonable access to appropriate medical services.
7. Participate actively with their physician in decisions regarding their medical care. To the extent permitted by law, they also have the right to refuse treatment.
8. A candid discussion of appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage.
9. Receive from their physician an understanding of their medical condition and any proposed appropriate or medically necessary treatment alternatives, including available success/outcomes information, regardless of cost or benefit coverage, so they can make an informed decision before they receive treatment.
10. Receive preventive health services.
11. Know and understand their medical condition, treatment plan, expected outcome, and the effects these have on their daily living.
12. Have confidential health records, except when disclosure is required by law or permitted in writing by them. With adequate notice, they have the right to review their medical record with their primary care physician.
13. Communicate with and receive information from member services in a language they can understand.
14. Know about any transfer to another hospital, including information as to why the transfer is necessary and any alternatives available.
15. Obtain a referral from their primary care physician for a second opinion, if required.
16. Be fully informed about the Blue Shield grievance procedure and understand how to use it without fear of interruption of health care.
17. Voice complaints or appeals about the health plan or the care provided to them.
18. Participate in establishing public policy of the Blue Shield health plans, as outlined in their *Evidence of Coverage* or *Health Service Agreement*.
19. Make recommendations regarding Blue Shield's member rights and responsibilities policy.

Member Rights and Responsibilities *(cont'd.)*

Statement of Member Responsibilities

Blue Shield health plan members have the responsibility to:

1. Carefully read all Blue Shield health plan materials immediately after they are enrolled so they understand how to use their benefits and how to minimize their out-of-pocket costs. Ask questions when necessary. They have the responsibility to follow the provisions of their Blue Shield health plan membership as explained in the *Evidence of Coverage* or *Health Service Agreement*.
2. Maintain their good health and prevent illness by making positive health choices and seeking appropriate care when it is needed.
3. Provide, to the extent possible, information that their physician, and/or the plan need to provide appropriate care for them.
4. Understand their health problems and take an active role in developing treatment goals with their medical care provider, whenever possible.
5. Follow the treatment plans and instructions they and their physician have agreed to and consider the potential consequences if they refuse to comply with treatment plans or recommendations.
6. Ask questions about their medical condition and make certain that they understand the explanations and instructions they are given.
7. Make and keep medical appointments and inform the plan physician ahead of time when they must cancel.
8. Communicate openly with the physician they choose so they can develop a strong partnership based on trust and cooperation.
9. Offer suggestions to improve the Blue Shield health plan.
10. Help Blue Shield to maintain accurate and current medical records by providing timely information regarding changes in address, family status, and other health plan coverage.
11. Notify Blue Shield as soon as possible if they are billed inappropriately or if they have any complaints.
12. Select a physician for their newborn before birth, when possible, and notify Blue Shield as soon as they have made this selection.
13. Treat all plan personnel respectfully and courteously as partners in good health care.
14. Pay their dues/premiums, copayments, coinsurance and charges for non-covered services on time.
15. For mental health and substance use disorder services, follow the treatment plans and instructions agreed to by them and Blue Shield's mental health service administrator (MHSA) and obtain prior authorization as required by the applicable plans *Evidence of Coverage* or *Health Service Agreement* for all non-emergency mental health and substance use disorder services. Medical services for the treatment of gender dysphoria, eating disorder or substance use disorder are the responsibility of Blue Shield.
16. Follow the provisions of the Blue Shield benefit management program.

Section 1: Introduction

Member Grievance Process

Blue Shield administers the investigation of member grievances. This process follows a standard set of policies and procedures for the resolution of grievances for both Blue Shield Medicare Advantage plan and Commercial HMO and PPO members. The process also encourages communication and collaboration on grievance issues among Blue Shield departments and functional areas. Blue Shield requests that contracted providers become familiar with the member grievance process and suggest members use it.

Although it is inadvisable to require patients to sign arbitration agreements as a condition of providing medical care, providers may choose to enter into arbitration agreements with Blue Shield plan members, providing the agreement to arbitrate fully complies with the California Code of Civil Procedure (CCP) Section 1295 including the important provision that the patient is permitted to rescind the arbitration agreement in writing within 30 days of signature, even when medical services have already been provided.

Blue Shield encourages members to resolve their grievances with their Blue Shield providers. If this is not possible, members, member representatives, or an attorney or provider on the member's behalf, may contact their Customer Service locations for initiation of the grievance process.

A member's grievance is defined as any of the following:

- Potential Quality Issues (PQI)
- Appeal – Standard or Expedited
- Complaint

Definitions

Potential Quality Issue (PQI) – Any suspected deviation from expected provider or health plan performance related to the quality of care and/or the quality of service provided to any Blue Shield or Blue Shield Life enrollee during a course of care or treatment, regardless of Line of Business. Possible examples include but are not limited to those listed below. PQIs may be categorized as followed:

- Access to Care
- Referral/Authorization Procedures
- Communication issues
- Provider/Staff Behavior
- Coordination of Care
- Technical Competence or Appropriateness
- Facility/Office Environment

Member Grievance Process *(cont'd.)*

Definitions *(cont'd.)*

Appeal – A request for Blue Shield’s or Blue Shield’s Life’s reconsideration of an initial determination (either verbal or written) which resulted in the following:

- Complete denial of service, benefit or claim
- Reduction of benefits or claim payment
- Redirection of service or benefits
- Delay of prospective authorization for service or benefits
- Eligibility related denials

Expedited Review or Expedited Initial Determination (EID) – Any denial, termination, or reduction in care, where the member feels that the determination was inappropriate and the routine decision making process might seriously jeopardize the life or health of the member, or when the member is experiencing severe pain. The expedited review process requires resolution and response to the member as soon as possible to accommodate the member’s condition not to exceed 72 hours of the member’s initial request. The member, his/her representative, or his/her physician on behalf of the member may file this request.

Complaint – An expression of dissatisfaction with a provider, provider group, vendor, or health plan that does not have a clinical aspect or claims monetary component to the issue.

Blue Shield Commercial Policy

All Blue Shield commercial members receive in their *Evidence of Coverage* or *Certificate of Insurance*, a Statement of Member Rights and Responsibilities.

Members, member representatives, or an attorney or provider on the member’s behalf, may file a grievance by contacting Blue Shield’s Customer Service Department in writing, by telephone, or by submitting a completed Grievance Form online at blueshieldca.com. Blue Shield researches and investigates all grievances and, as appropriate, the Blue Shield Medical Director may review a grievance.

In compliance with the Department of Managed Health Care (DMHC), California Department of Insurance (CDI), legislative requirements, and NCQA, Blue Shield will resolve all member grievances within 30 calendar days of receipt.

When appropriate, Blue Shield will send copies of the member’s correspondence to the provider and request that he/she review and respond in writing to the Blue Shield Medical Director.

Section 1: Introduction

Member Grievance Process *(cont'd.)*

Blue Shield Medicare Advantage Plan Policy

All Blue Shield Medicare Advantage plan members receive in their *Evidence of Coverage* a Statement of Member Rights and Responsibilities. If a Blue Shield Medicare Advantage plan member asks about filing a grievance, complaint, or an appeal, the member should be referred to Blue Shield Medicare Advantage Member Services.

The Blue Shield Medicare Advantage Appeals and Grievance Resolution Department will acknowledge receipt of the member's concern within five calendar days of receipt and provide the member with the name and phone number of the person working on their concern. The complaint will be resolved within 30 calendar days of receipt. Post service appeals (claims) are resolved within 60 days.

If the member is not satisfied with the initial resolution of the grievance or complaint, the member may file a written request for a grievance hearing. The grievance hearing will be scheduled within 31 days of receipt of request and will be held at the Blue Shield Woodland Hills office location. The panel will include a Blue Shield Medicare Advantage plan Medical Director and a representative from the Blue Shield Medicare Advantage Appeals and Grievances Department.

All grievances are researched and investigated by the Blue Shield Medicare Advantage Appeals and Grievance Resolution Department, and, as appropriate, reviewed by a Blue Shield Medical Director. Medicare policy, such as Medicare National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs), must be applied in the review of appeals by Blue Shield Medicare Advantage plan members.

If a member, member representative, or physician files a grievance, appeal or complaint, you may be required to provide medical records for review as part of the review process. As a Blue Shield contracted provider, you are responsible for the maintenance of a member's medical records and the timely submission of any and all requested documentation considered as part of the review process.

Standard Review Process

The standard review process for member grievances allows a 30 calendar day period of resolution from the date the grievance is received by Blue Shield to the time the member is informed of the decision. When the grievance is received, Blue Shield will acknowledge receipt of the member's grievance within five calendar days of receipt and provide the member with the name of a person to contact regarding their grievance. Generally, the member must participate in Blue Shield's grievance process for 30 calendar days before submitting a complaint to the DMHC or CDI. The DMHC or CDI can waive this requirement in "extraordinary and compelling cases." In these events, Blue Shield has five working days to respond to the grievance. The Blue Shield grievance system allows members to file grievances within 180 days following any incident or action that is the subject of the enrollee's dissatisfaction.

Member Grievance Process *(cont'd.)*

Expedited Review

In keeping with the Knox Keene Act, Blue Shield provides an expedited review process in those circumstances where a member believes that his/her health or ability to function could be seriously harmed by waiting the 30 calendar days for a standard grievance. There are specific criteria that must be met in order for a grievance to be considered expedited. If there is a question as to whether a specific grievance qualifies, the member, member representative, or an attorney or provider on behalf of the member may contact Customer Services and request an expedited review. If the grievance meets the expedited criteria, the case will be handled within the expedited review process. If the grievance does not meet the criteria, the member will be informed of this decision and the review will be conducted under the standard review process guidelines. The expedited review process requires resolution and response to the member as soon as possible to accommodate the member's condition not to exceed 72 hours of the member's initial request. The member, his/her representative, his/her attorney or his/her physician on behalf of the member may file this request. The Blue Shield grievance system allows members to file grievances within 180 days following any incident or action that is the subject of the enrollee's dissatisfaction.

External Review

If a member's grievance involves a claim or services for which coverage was denied in whole or in part by Blue Shield, on the grounds that the service is not medically necessary or is experimental/investigational (including the external review available under the Friedman-Knowles Experimental Treatment Act of 1996), the member may choose to have the matter submitted to an independent agency for external review in accordance with California law. The member normally must first submit a grievance to Blue Shield and wait for at least 30 days before requesting external review; however, if the matter would qualify for an expedited decision as described above, the member may immediately request an external review. The member may initiate this review by completing an application for external review, a copy of which can be obtained by contacting Blue Shield Member Services. The DMHC or CDI will review the application and, if the request qualifies for external review, will select an external review agency for an independent opinion. There is no cost to the member for this external review. The member and their physician will receive copies of the opinions of the external review agency. This external review agency is binding on Blue Shield. This process is completely voluntary on the member's part; the member is not obligated to request external review.

External Exception Review

If Blue Shield denies an exception request for coverage of a Non-Formulary Drug, Step Therapy or a Prescription Drug Prior Authorization, the Member, authorized representative, or the Provider may submit a grievance requesting an external exception request review. Blue Shield will ensure a decision within 72 hours in routine circumstances or 24 hours in exigent circumstances. This review process applies to plans regulated by the DMHC or CDI.

Contacting the Appeals and Grievance Department

To contact the Appeals and Grievance Department, please refer to the *Contact us* section at the top of Provider Connection at blueshieldca.com/provider.

Section 1: Introduction

Fraud Prevention

Each year hundreds of millions of dollars are lost due to health care fraud, waste, and abuse. The mission of the Blue Shield Special Investigations Unit (SIU) is to ensure we provide the best investigative services for the company and stakeholders by being nimble and highly responsive to a broad spectrum of suspected fraudulent activities. The SIU is accountable for leading in investigations and criminal/civil prosecutions of internal and external entities and is the primary liaison with all levels of law enforcement. In conjunction, the SIU coordinates efforts to recover erroneous payments, misrepresentative billing, fraud, abuse or other acts resulting in overpayments.

Providers can help us to stop this pervasive problem by reporting suspicious incidents. To learn more, as well as how and what to report, go to Provider Connection at blueshieldca.com/provider, click on the *Privacy* link at the bottom, and then the *Fraud Prevention* link to the left. Here, providers can get guidance related to billing practices and prevention of inappropriate practices. Investigators in the Special Investigations Unit research suspicious billing practices.

Providers can also email Special Investigations directly at stopfraud@blueshieldca.com, or call Blue Shield's 24-hour Fraud hotline at the toll-free telephone number (855) 296-9092. Callers and emailers may remain anonymous, if desired. All reporting is confidential.

Provider Audits

The Blue Shield Special Investigations Unit (SIU) has the duty and responsibility to conduct periodic provider audits. The SIU monitors and analyzes billing practices in order to ensure services are correctly billed and paid.

Audits are also conducted to ensure compliance with:

- Blue Shield of California Medical, Medication and Payment Policies
- Accepted CPT, HCPCS, ICD-10-CM, and ICD-10-PCS billing and coding standards
- Scope of Practice
- Blue Shield's policies and procedures on claims submissions
- State and federal laws and regulations

All audits comply with federal and state regulations pertaining to the confidentiality of patient records and the protection of personal health information.

SIU personnel shall contact the provider's office to schedule onsite audits five (5) business days in advance or earlier if mutually agreed upon. The provider shall allow inspection, audit and duplication of any and all records maintained on all members to the extent necessary to perform the audit or inspection. This includes any and all Electronic Health Records (EHR) and systems including any electronically stored access logs and data entry for electronic systems. Blue Shield requires that all records and documentation be contained in each corresponding Patient chart at the time of the audit. Audit findings will be communicated in writing.

Provider audits may result in a determination of overpayment and a request for refund. Please refer to Section 4, Billing, Claim Inquiries and Corrected Billings, Overpayments for information on the Blue Shield's process and procedures for notification of overpayments and offset.

Fraud Prevention *(cont'd.)*

Fraud, Waste, and Abuse

The Medicare Prescription Drug benefit has been implemented by the Centers for Medicare & Medicaid Services (CMS) to allow all Medicare beneficiaries access to prescription drug coverage. In its effort to combat fraud in the Medicare prescription drug program, CMS has added several Medicare Drug Integrity Contracts (MEDICs). In California, the MEDIC is Qlarant Integrity Solutions, LLC. Qlarant Integrity Solutions, LLC is responsible for monitoring for fraud, waste, or abuse in the Medicare Part C and Part D programs on a national level.

Qlarant Integrity Solutions, LLC has been authorized by CMS to monitor Medicare fraud, waste, and abuse and to investigate any beneficiary complaints related to Medicare Part C & D benefits.

Qlarant Integrity Solutions, LLC is interested in receiving reports of potential fraud, waste, or abuse from Medicare beneficiaries. Examples of these types of complaints may include:

- An individual or organization pretends to represent Medicare and/or Social Security, and asks the beneficiary for their Medicare or Social Security number, bank account number, credit card number, money, etc.
- Someone asks the beneficiary to sell their Medicare prescription ID card.
- Someone asks the beneficiary to get drugs or medical services for them using their Medicare ID card.
- The beneficiary feels a Medicare Advantage or standalone Part D plan has discriminated against them, including not letting them sign up for a specific plan because of their age, health, race, religion, or income.
- The beneficiary was encouraged to disenroll from their current health plan.
- The beneficiary was offered cash to sign up for a Medicare Advantage or standalone Part D plan.
- The beneficiary was offered a gift worth more than \$15 to sign up for a Medicare Advantage or standalone Part D plan.
- The beneficiary's pharmacy did not give them all of their drugs.
- The beneficiary was billed for drugs or medical services that he/she didn't receive.
- The beneficiary believes that he/she was charged more than once for their premium costs.
- The beneficiary's Medicare Advantage or standalone Part D plan did not pay for covered drugs or services.
- The beneficiary received a different drug than their doctor ordered.

Medicare beneficiaries should contact Qlarant Integrity Solutions, LLC at (877) 772-3379 to report complaints about any of these types of fraud, waste and abuse issues or a related complaint. Qlarant Integrity Solutions, LLC may also be contacted via facsimile at (410) 819-8698 or at their website qlarant.com. Reports may also be submitted directly to Blue Shield's Special Investigations Unit at (855) 296-9092, the Medicare Compliance Department at (855) 296-9084, or via email at stopfraud@blueshieldca.com. All reporting is confidential and may be submitted anonymously.

Section 1: Introduction

Fraud Prevention *(cont'd.)*

Medicare Compliance and Fraud, Waste, and Abuse Training Requirements

Blue Shield has a comprehensive program in place to detect, prevent and control Medicare Fraud, Waste, and Abuse (FWA) as part of the General Compliance Plan Requirements (42 C.F.R. § 423.504(b)(4)(vi)(H)) and 42 C.F.R. § 422.503(b)(4)(vi).

Blue Shield requires all First-Tier, Downstream, and Related Entities (FDRs), including but not limited to IPAs, medical groups, providers, independent sales agents, third party marketing organizations (TMOs), and contracted pharmacies who work with the Medicare Program that they successfully complete a fraud waste and abuse (FWA) training. This training should focus on how to detect, correct, and prevent non-compliance and fraud, waste, and abuse surrounding Medicare programs.

All FDRs must ensure that all personnel, Board members, employees and contracted staff involved in the administration or delivery of Medicare benefits complete a FWA training, alternative equivalent training through another Medicare Plan Sponsor, the CMS web-based Compliance and FWA training, or deemed through enrollment into the Medicare program or accreditation as a durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) supplier.

This requirement applies to all personnel, employees, and contracted staff upon initial hire. Evidence of training must be maintained for a minimum of ten (10) years and produced upon request for audit purposes. Training must be completed within 90 days of hire or election to the Board and annually thereafter.

A statement of attestation is required annually by all IPAs, medical groups, and network pharmacies contracted with Blue Shield for the Medicare programs. The compliance statement of attestation indicates that the IPA, medical group or pharmacy staff and downstream providers have completed the Medicare Compliance and Fraud, Waste, and Abuse training, equivalent training from another Plan Sponsor, or the CMS web-based compliance and FWA training that is accessible at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining>).

Blue Shield’s Code of Conduct and the Corporate Compliance Program

Blue Shield is subject to a wide variety of federal, state, and local laws. These include, but are not limited to, laws governing confidentiality of medical records, personally identifiable information, health plan and insurance regulatory requirements, government contracts, kickbacks, fraud, waste, and abuse, false claims and provider payments.

Blue Shield’s Code of Conduct is the foundation of our Corporate Compliance Program, which is designed to prevent, detect and remediate unlawful and unethical conduct by Blue Shield personnel, as well as to promote a corporate culture of integrity. In doing so, the Program is designed to create an environment that facilitates the reporting of actual or suspected violations of the Code and other misconduct without fear of retaliation.

Reporting misconduct demonstrates transparency, responsibility, and integrity to other workforce members, business partners, Board members, and our customers. It also serves to protect our Company, brand, and reputation. We all “own” compliance and integrity with our daily conduct and decisions.

Providers can make confidential reports of concerns via the Compliance & Ethics Help Line at (888) 800-2062 or report actual or potential violations anonymously via the Compliance & Ethics Hot Line at (855) 296-9083. To view Blue Shield’s Code of Conduct, click the link below:

[Blue Shield of California Code of Conduct](#)

If providers have additional questions about this program, please contact Provider Information & Enrollment at (800) 258-3091.

Section 1: Introduction

Blue Shield Medicare Advantage Program Overview

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 – Prescription Drug (MA-PD) plans).

Blue Shield’s Medicare Advantage-Prescription Drug 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 Advantage plan, have paid any premiums required for initial enrollment to be valid, and whose enrollment in 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.

The Blue Shield Medicare Advantage plans provides comprehensive coordinated medical services to members through an established provider network. Similar to the commercial HMO product, Blue Shield 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 plans are regulated by CMS, the same federal agency that administers Medicare.

Blue Shield Medicare Compliance Program

The Medicare Modernization Act (MMA) established the Medicare Advantage (MA) Program, building on the prior compliance requirements for health plans contracted under the Medicare program. The MMA added Medicare Part D and new coverage for prescription drugs and continued to build on the program integrity provisions in the Balanced Budget Act of 1997. Medicare Advantage Organizations and Part D Sponsors are required by CMS to have a compliance program in place through which the organization establishes and maintains compliance with all federal and state standards. Moreover, provisions in the Affordable Care Act (ACA) require that the compliance program be “effective” in preventing and correcting non-compliance with Medicare Program requirements and fraud, waste, and abuse.

The compliance program must include:

- Written Policies, Procedures, and Standards of Conduct
- Compliance Officer, Compliance Committee and High Level Oversight
- Effective Training and Education
- Effective Lines of Communication
- Well Publicized Disciplinary Actions
- Effective System for Routine Monitoring, Auditing and Identification of Compliance Risks
- Procedures and System for Prompt Response to Compliance Issues

Blue Shield Medicare Compliance Program *(cont'd.)*

Blue Shield has a Corporate Compliance Program in place that includes four primary components:

- Model policies for employee, officer and director conduct
- Code of business conduct
- Toll-free hotline for reporting actual or suspected violations
- Special investigations team for fraud and abuse reviews

All the components in our Corporate Compliance Program are supported by Blue Shield values which include: doing the right thing; placing customers at the center of what we do; keeping promises; being creative and taking risks; creating an environment that promotes personal, professional, and team fulfillment; and being responsible for maintaining Blue Shield's heritage. Leadership principles reinforce our organizational commitment to our company values.

While the existing Corporate Compliance Program remains the foundation for our organizational compliance, a separate compliance structure was established for the Medicare Advantage Program and the Medicare Part D Programs. Medicare Compliance is supported by a dedicated team. Under the oversight of Blue Shield's Vice President, Chief Compliance & Ethics Officer, the Medicare Compliance Department handles communication with CMS and the Blue Shield operating departments regarding the Medicare plans. A dedicated team headed by the Director of Medicare Compliance, Medicare Compliance Managers, staff of compliance analysts and auditors, and delegated claims compliance and performance auditors advise about CMS requirements and monitor compliance within the organization and in relation to Blue Shield's representatives in the community. The Director of Medicare Compliance leads the day-to-day operations of the Medicare Compliance function and reports directly to the VP, Chief Compliance & Ethics Officer, who provides direct and periodic reports to Blue Shield's Board of Directors (Audit Committee), the company's Chief Executive Officer (CEO) and senior management on relevant Medicare Compliance and other Corporate Compliance issues, as appropriate. The Medicare Compliance Department builds on components of our Corporate Compliance Program and Code of Conduct, and the work of the Privacy Office, which is responsible for the oversight of Blue Shield's compliance with state and federal privacy laws, including the privacy components of the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH).

The Director of Medicare Compliance chairs the Plan's Medicare Compliance Committee, which has representation from all areas of the company that touch the Medicare programs. The Committee serves as the forum for program direction and oversight relative to operating requirements, performance measures and the definition and implementation of effective corrective actions, when indicated. The Medicare Compliance Committee, and Medicare Compliance Department staff, as well as the Blue Shield team of internal auditors, validates the continuing compliant operations of functional areas within the company and the compliant performance of contractors and agents through:

- Monitoring, auditing performance and regulatory compliance
- Auditing of delegated and downstream providers' compliant execution responsibilities
- Monitoring of corrective actions imposed by internal and external entities
- Training and education of employees, temporary employees, and contracted providers and agents in Medicare program requirements and Blue Shield policies on privacy, compliance, fraud, waste, and abuse detection and reporting
- Tracking of changes in CMS requirements and educating operating units, accordingly
- Verifying current written policies and procedures
- Tracking and submission of required certifications and reporting to CMS

Section 1: Introduction

Blue Shield Medicare Compliance Program *(cont'd.)*

The Medicare Compliance Program sets the framework for our oversight vision and processes, and lays out monitoring programs and activities relative to our overall compliance with CMS regulatory requirements. It is our expectation that the Medicare Compliance Program will not only enable Blue Shield to meet increasing CMS requirements, but also to improve the quality of care and service provided to our Medicare Advantage and Medicare Part D members. The overall compliance structure incorporates the Code of Conduct and the Compliance Program to promote ethical behavior, equal opportunity, and anonymity in reporting of any improprieties within the Medicare product or elsewhere within the organization. Blue Shield has and enforces a strict non-retaliation policy for reporting actual or suspected legal, policy or Code violations, or any other misconduct, in good faith. Key compliance indicators or benchmarks, as well as concerns raised through internal and external monitoring activities, are reviewed by the Medicare Compliance Committee to help proactively identify potential issues and facilitate internal corrective actions or policy changes, as indicated. These elements of the Blue Shield Medicare Compliance Program provide examples of policies and programs that providers might wish to establish within their own organizations.

Auditing and Monitoring

Blue Shield has various departments, e.g., Provider Claims Compliance and Delegation Oversight, that audit first-tier entities for compliance with CMS Program requirements. However, providers are tasked with the oversight and audit of the entities with which they contract to ensure compliance with Medicare Program requirements. Upon request, providers must provide the results of the monitoring and auditing of their downstream entities.

Confirmation of Eligibility of Participation in the Medicare Program

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) maintains a sanction list that identifies those individuals and entities found guilty of fraudulent billing, misrepresentation of credentials, etc. Delegated entities managing Medicare members are responsible for checking the sanction list at minimum on a monthly basis to ensure their Board of Directors, owners or employees are not on the list. The delegated entity, its MSO, or any sub-delegates are prohibited from hiring, continuing to employ, or contracting with individuals named on the OIG List of Excluded Individuals and Entities (LEIE) and the GSA Excluded Parties Lists System (EPLS). Below are links to the LEIE and EPLS:

- <https://oig.hhs.gov/exclusions/index.asp>
- <https://www.sam.gov/portal/SAM>

Upon audit, providers must provide evidence that you are checking your employees, temporary workers, Board of Directors against the excluded provider data bases upon hire, contracting, or election to the Board, and monthly thereafter.

Healthcare Regulatory Agencies

California Department of Insurance (CDI)

The California Department of Insurance (CDI) is responsible for regulating health insurance. The Department's Health Claims Bureau has a toll-free number (800) 927-HELP (4357) or TDD (800) 482-4833 to receive complaints regarding health insurance from either the insured or his or her provider. If you have a complaint against your insurer, you should contact the insurer first and use their grievance process. If you need the Department's help with a complaint or grievance that has not been satisfactorily resolved by the insurer, you may call the Department's toll-free telephone number 8a.m. to 5p.m., Monday - Friday (excluding holidays). You may also submit a complaint in writing to: California Department of Insurance, Health Claims Bureau, 300 S. Spring Street, South Tower, Los Angeles, California 90013, or through the website at <http://www.insurance.ca.gov/01-consumers/101-help>.

California Department of Managed Health Care (DMHC)

The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. If the member has a grievance against Blue Shield, they should first telephone Blue Shield at the number provided in their Evidence of Coverage booklet and use our grievance process before contacting DMHC. Utilizing Blue Shield's grievance process does not prohibit any potential legal rights or remedies that may be available to the member. If the member needs help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by Blue Shield, or a grievance that has remained unresolved for more than 30 days, the member may call DMHC for assistance. The member may also be eligible for an Independent Medical Review (IMR). If they are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by Blue Shield related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services.

Providers can reach the DMHC at (888) 466-2219, TDD line (877) 688-9891 for the hearing and speech impaired, or through www.dmhc.ca.gov, where complaint forms, IMR application forms, and instructions can be found.

Centers for Medicare & Medicaid Services (CMS)

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that administers the Medicare program. Blue Shield has entered into contracts with CMS to provide benefits to Medicare beneficiaries. Blue Shield's Medicare Advantage-Prescription Drug plans are open to all individual Medicare beneficiaries who have Medicare Part A and Part B, who permanently reside within the plan service area, and who do not have End-Stage Renal Disease at the time of enrollment in the MA-PD plan. Blue Shield also offers a group Medicare Advantage-Prescription Drug plan to Medicare beneficiaries retired from employer groups/unions who have selected the product as an option.

Blue Shield's stand-alone Medicare prescription drug plans are open to all individual Medicare beneficiaries who have Medicare Part A and/or Part B and permanently reside within the plan's service area. Additionally, Blue Shield offers a group Medicare prescription drug plan to Medicare beneficiaries retired from employer groups/unions who have selected the product as an option. Information about CMS or the Medicare program is available by calling (800)-MEDICARE [(800) 633-4227] and through the websites medicare.gov and cms.hhs.gov.

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